

Voices from the Periphery: A Narrative Study of the Experiences of Sexuality of Disabled Women in Zimbabwe



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Thesis Presented for the Degree of

Doctor of Philosophy

Disability Studies

Department of Health and Rehabilitation Sciences

University of Cape Town

December 2015

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Acknowledgements

I would like to thank the 16 disabled women who participated in this research, for not just giving me words, but for sharing with me the most intimate details of their life worlds. What I learnt from the women has not only humbled me, but it has also challenged me and left an indelible mark in my own life. I can only hope that I have accurately presented the women's voices, in my efforts to contribute towards making positive individual and societal change.

I feel honoured to have been supervised by Dr Judith McKenzie, Professor Harsha Kathard and Dr Adelene Africa. I will forever be grateful to them for helping me to think systematically, for believing in me even during those moments when I doubted myself and for persistently reading and critiquing my work. I also thank the international Biographic Narrative Interpretive Method (BNIM) expert, Tom Wengraf, for humorously guiding and supporting my novice entry into the world of the BNIM method.

I am grateful to the National Association of Societies for the Care of the Handicapped (NASCOH) and the Disabled Women Support Organisation (DWSO) who gave me insight into the research terrain, the Dorothy Duncan Centre for the Blind and Physically Handicapped who translated relevant research documents to Braille and the sign language interpreter who devotedly facilitated communication between me and the Deaf participants.

My sincere gratitude also goes to my wonderful family that stood by me throughout the complex and stressful journey of my studies and for enduring my neglect during the long hours that I spent on the computer. I thank especially Tapfuma for his encouragement, support, patience and tolerance of me throughout my study voyage.

I am appreciative of my University of Cape Town colleagues Callista and Amshuda for sharing with me their study ideas.

Last but not least, I will forever be grateful to the institutions that funded my studies and in particular: Canon Collins Legal and Educational Trust, Margaret McNamara Scholarship Fund (World Bank) and the Council for the Study of Social Science Research in Africa (CODESRIA). Without their support this study may not have been a success.

Dedication

I dedicate this thesis to my mother Ronica, who taught me the value of resilience and hard work, as well as to all the disabled women who allowed me to enter their private lives through their participation in this study.

Abstract

This thesis is located within a conceptual framework which integrates related theoretical concepts under an overarching critical feminist disability studies lens. The study sought to explore within an African context, the experiences of sexuality of 16 disabled women in Zimbabwe by using a narrative methodology. The Biographic Narrative Interpretive Method was used to generate data and a three phased approach to analysing data was used by employing narrative analysis in the first level to produce whole life stories and analysis of narratives at the second level to produce distinctive themes from the stories. The third level of analysis builds on the second level of analysis and in this study it is embedded in the discussion of findings where it represents a latent and deeper layer of analysis which seeks to further understand the data. The findings that emerged from the first level narrative analysis illuminate the biographic specificity of the experiences of sexuality of disabled women, albeit drawing belief systems from the wider national context. At the second level, the cross-case analysis generated thematic findings which revealed that all participants dynamically engage in intimate partner relationships. In addition, participants are vulnerable to gender based violence, including in matrimonial relationships, in a setting where silences that surround issues of sexuality are detrimental to the well-being of participants. The third level of analysis illuminates the fact that disabled women are not passive recipients of disability and sexuality stereotypes but they claim their agency and create opportunities for themselves in the area of sexuality. Participants value heterosexual marriage in a context where different sexual orientations are despised by culture and same sex marriages are prohibited by the constitution of Zimbabwe. The complex intersection of culture, disability and normative gender roles and power relations within heteronormative relationships facilitate the vulnerability of disabled women to unsafe sexual practices which exacerbate their vulnerability to HIV infection, in a context which is characterised by a lack of sexuality education. This study makes a contribution towards the development of indigenous theoretical formulations of disability and sexuality that are rooted in the African context. I conclude in part, that the experiences of sexuality of disabled women in Zimbabwe disrupt the common myth that disabled women are asexual beings. Through asserting and expressing their sexuality, the women constantly distinguish themselves with multiple identities as they negotiate the heteronormative sexual terrain of Zimbabwe. I hope that this study will instigate further research in this understudied area, particularly in the Global South and including in African countries.

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List of Acronyms

AFDS	African Feminist Disability Studies
AIDS	Acquired Immune Deficiency Syndrome
BNIM	Biographic Narrative Interpretive Method
CEDAW	Convention on the Elimination of all kinds of Discrimination against Women
DPA	Disabled Persons Act
DQAC	Doctoral Quality Assurance Committee
CRPD	Convention on the Rights of Persons with Disabilities
DWSO	Disabled Women Support Organisation
ESAP	Economic Structural Adjustment Programme
FDS	Feminist Disability Studies
FGM	Female Genital Mutilation
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
NASCOH	National Association of Societies for the Care of the Handicapped
NGO	Non-governmental Organisation
USA	United States of America
UK	United Kingdom
UN	United Nations
UNESCO	United Nations Educational Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UPIAS	Union of the Physically Impaired against Segregation
WHO	World Health Organization
SIDA	Swedish International Development Agency

PROLOGUE

The beginning of a thesis that claims to be a narrative inquiry deserves the telling of a story in its commencement (Trahar, 2006). I therefore start off by telling my story as the researcher in this prologue. I have experienced disability both as a child and as an adult through living with my disabled family members and working with people with disabilities later on in my life. I was raised in a big family with parents who were always ready to welcome into our small home both disabled and non-disabled members of our extended family, in spite of our meagre resources: my father, a then devoted clothing factory tailor and my mother a hardworking innovative housewife who equally ran our rural and urban homes to the utmost of her ability. Having known poverty at a tender age, a basic education, marriage and employment saw me escaping my underprivileged status in the mid-years of my early adult life. My later employment in the international development sector earned me some travel to parts of the USA, Europe and other countries in Southern Africa, thereby opening doors of exposure and opportunity for me.

In a Zimbabwean context where poverty and prosperity are intimately related, my then newly acquired social standing served to fulfil the Shona proverb *kugarike tange nhamo* (success comes after poverty). However, on reflection, I realise that my shift to a middle class socio-economic position has not obliterated the physical, cognitive, sexual and social prints of poverty, an identity-marker which forms a primary part of my origin. My personal epistemologies arise from such experiences and are strengthened and moulded by my transformation in this world, albeit with my allegiances that remain grounded in such an identity. My heart therefore lies with facilitating the voice of those who live in the zone of my roots: the zone of invisibility, silence and the margins.

In the early years of my career, I was employed in an administrative capacity and my work with the United Nations Educational Scientific and Cultural Organisation (UNESCO) was the first to expose me to the world of development work. I pursued studies which were in line with my then nature of work until I acquired a Master's Degree in Business Administration (MBA) and, subsequently moved from my career location at the time to a management position with an international NGO. Although I was tasked with administratively supporting programmes that sought to reduce suffering and poverty, I became dissatisfied with my own

career discipline and its integral paradigm of positivism. I therefore went back to college to take courses that promised to take me directly and technically back to the margins, albeit in a different locus. I obtained a Master's Degree in Development Studies (MDS), which then marked the beginning of my "crossbreed" professional position.

My newly acquired qualification earned me a senior position in a capacity building NGO, but my strong personal connection with disabled people and my interaction with them in the line of my duties motivated my desire to study and work specifically in the disability sector. In particular, this study was born out of the uneasiness I felt when a woman who is disabled with dwarfism, and the only visibly impaired woman who was attending a national women's development conference that I was running, mentioned that she had been disappointed by her male intimate partner. I was immediately thrown off balance: after all I had not included such a subject on my list of "important" topics for the conference. Although I thought I had a fair understanding of disability issues, I immediately saw a knowledge gap within myself as well as a disabled woman's hunger to be heard on a topic of her concern.

In my then amazement, several questions ran through my mind: "With such impairment, how can she possibly have a boyfriend? What does she really need the guy for? Why does she even bother? Isn't her impairment enough trouble on its own? Besides, how can a woman go off topic just like that at such a corporate forum?" At that time my mind was fraught with misconceptions which limited my understanding of the subject of sexuality to purely the 'meeting' of genitals of two people of the opposite sex and nothing more. However, for some reason, I felt that I had not done justice to the questions of sexuality that the disabled woman had advanced at the time; I therefore set off on my journey as a novice researcher of both disability and sexuality. In undertaking this study, I have carried that woman in my heart, who is the very same woman who later became my close friend, together with all the women who participated in this study. On reflection, I realise that my PhD studies are a result of both my personal, academic and professional biography. I introduce this study in Chapter 1, below.

CHAPTER ONE

INTRODUCTION

*Is it true that you want to know? Do you really want to know...?
What do you really want to know...? Why not get it from the horse's mouth...
(Girlie cited in Chataika, 2005, p. 2)*

Figure 1: A participant's home



In this study, I sought to explore the experiences of sexuality of disabled women in Zimbabwe. Disabled women represent one of the most marginalised minority groups in the world (Leonard Cheshire Disability, 2014), hence they remain silent while their sexuality is ignored, suppressed, forbidden and buried underneath the carpet (Ball, n.d.; Banks & Kaschak, 2003). When I embarked on this study, I had hoped to draw literature from local studies that would have been undertaken on the subject, but my hopes were crushed when my contextual literature search proved fruitless. The reality is that very little literature on the topic has been published in the Global South and most published literature on this topic emanates from the Global North. According to Odeh (2010), Global Northern countries are those nations that are economically developed such as the USA, the UK, Canada, Western European nations and developed parts of Asia; Global Southern countries are those that are less economically developed such as nations in Africa and some parts of Asia.

Until recently, most of the Global Northern published literature on the subject of the sexuality of disabled women has predominantly been constructed from hearsay and second-hand narratives in studies which draw from the perspectives of parents, service providers and advocates, without much consultation of the relevant women (Dotson, Stinson, & Christian, 2003). Such a power of recounting experiences is pronounced by Achebe (2000, p. 17), “There is such a thing as absolute power over narrative. Those who secure this privilege for themselves can arrange stories about others pretty much where, and as they like. Just as in corrupt, totalitarian regimes, those who exercise power over others can do anything.” By facilitating the voice of disabled women in Zimbabwe, this study sought to challenge such power and privilege practices. As such the study created space in which disabled women directly contributed towards bringing their experiences of sexuality from the periphery of society to the fore.

This study evaded an exclusionary deportment by being open to all sexual orientations. However, Zimbabwe is a heteronormative society, in which alternative sexual orientations are silenced by both culture and law. Many Africans in Zimbabwe believe that homosexuality is an alien “disease” which was brought into the country by White settlers (Epprecht, 1998, 2013). However, a study carried out by Epprecht (1998) contradicts such a perspective by highlighting that although White people are blamed, homosexual behaviours have historically been prevalent in Zimbabwe even before the colonial era, albeit being traditionally disapproved of. Nevertheless, local people believe that the “disease” of homosexuality

spreads through ambassadors and tourists from the Global North, thereby threatening the family values of the African people. Any signs of homosexual orientation are in some instances linked to either witchcraft or an evil spirit and are dealt with privately and at family level. From a legal perspective, same sex marriages are prohibited, as articulated in the country's constitution (Government of Zimbabwe, 2013). It therefore follows that the heterosexual ambiances that emerged in this study were not meant to reproduce dominant heteronormative structures but rather reflect the individual women's experiences within a particular social context.

In exploring the experiences of sexuality of disabled women in Zimbabwe, this study was guided by the principle of exploration positioned within the narrative qualitative research paradigm. The principle of exploration enabled this study to create space within a critical qualitative framework for the facilitation of the silenced voices of disabled women. The narrative qualitative approach enables people to construct meaning by narrating their stories and describing how it feels to experience something (Creswell, 2000; Gray, 2009), thereby rendering it suitable for this research which sought to exhume the silent voice of disabled women by using a less structured, exploratory, flexible and free will approach. The current situation in Zimbabwe is that the voice of disabled women is rarely heard; hence whilst it is not my intention to generalise the findings of this study, I argue that this first narrative study of the experiences of sexuality of disabled women in Zimbabwe will make a significant contribution towards filling in a blank spot of knowledge about such experiences within a context which I discuss below.

1.1 Context of the study

In this section, I discuss the context of this study with the aim of framing the setting from which the research problem and questions naturally arise. Below, I present, in Figure 2, the geographic location of the research and thereafter I give an overview of the political, social and economic context in which this study took place.

Figure 2: Geographic location of research



Source:

<http://www.bing.com/images/search?q=map+of+zimbabwe+&go=Submit+Query&q=bs&form=QBIR#view=detail&id=0D78D20870C6B3D2D142D6743562858F6C91C369&selectedIndex=189>

Zimbabwe is a beautiful landlocked country which is located in Southern Africa between the Limpopo and Zambezi rivers and it borders Botswana, Zambia, Mozambique and South Africa (Duri et al., 2013; Muderedzi & Ingstad, 2011). The country carries an almost century long history of British colonisation which began in 1890 and ended in 1980, after a 15 year long (1964 – 1979) war of liberation against the White settler regime (Mpofu & Harley, 2002). Zimbabwe's capital, Harare, encompasses most of the Shona speaking people, who represent about 80% - 82% of the national population (Africaw, 2015; Duri et al., 2013; Mpofu & Harley, 2002). The Shona therefore form the largest ethnic group in the country followed by the Ndebele who represent approximately 16% - 18% of the country's population, leaving the other 2% to citizens of mainly European and Asian origin. Post-

colonial Zimbabwe has been rated a Christian nation with approximately 85% of the population following the Christian religion (Religion in Zimbabwe, 2012). However, most of the Christians, have not “resigned” from the African tradition under which the pre-colonial authority of the ancestors has continued to prevail (Chavhunduka, 2001). As such, most people in Zimbabwe hold some form of Christian church membership, whilst at the same time they consult traditional healers and believe in witchcraft within an economic context which I discuss below.

With a diversified economy which leans more towards agriculture, tourism and mining, Zimbabwe boasts a plethora of natural resources which include minerals such as gold, nickel, copper, diamonds, the majestic Victoria Falls (one of the seven wonders of the world), national parks, vast areas of arable land, forests and wild animals (Duri et al., 2013). The country is also credited with a literacy rate of 90%, one of the highest in Africa; a rate that has been attributed to the fact that after gaining independence from British rule in 1980, the government offered free education and free healthcare to the Black majority. However, although the government was able to maintain a well functioning economy for almost two decades after independence, the overturning of such gains became evident in the late 1990s/early 2000, when the country began to experience an economic decline. Muchetu (2015) states that as a result, the country has seen disabled children dropping out of school without completing primary school education or not attending school at all, due to a lack of appropriate facilities in mainstream schools and parents failing to afford the fees that are charged by private special schools, which are beyond the affordability of many.

Among other things, the economic downturn has been ascribed to pressures that arose from macro-economic changes of the economic structural adjustment programme (ESAP) of 1991 (Rippenburg, 1997), the advent of HIV/AIDS, a low agricultural output, political instability and a high level of corruption (Duri et al., 2013). The same authors state that the country’s inflation rate, which was recorded at 32% in 1998, rose to a high 11 200,000% in 2008 resulting in the country abandoning its own currency and adopting the United States Dollar in early 2009. Although Zimbabwe has received foreign loans from some African lenders, the IMF and the World Bank stopped advancing support to Zimbabwe in 1999. In addition, the country has lost a huge number of its professionals, including healthcare professionals, to other countries and the high healthcare costs have seen the majority of Zimbabweans who are now living in abject poverty, being unable to access medical care. To sum up the nature and

level of economic development in Zimbabwe, one can say that the country is a low-income country which is currently experiencing economic difficulties. However, the government's focus on turning around the country's economy and on reducing the impact of HIV resulted in the neglect of other social areas, among them being the disability sector.

The Government of Zimbabwe Social Welfare Assistance Act (Government of Zimbabwe, 1988), Chapter 17:06, makes provision for the extension of aid to enhance the social well-being of disabled people and their dependants through the government Department of Social Welfare (Manatsa, 2015; Mandipa & Manyatera, 2014). However, the department lacks capacity, and it is also under-funded and under-resourced, thereby making it difficult for the unit to fulfil its mandate. "The plight and situation of women with disabilities is particularly precarious, who are...subjected to harassment, sexual abuse and exploitation. Also, within a patriarchal society, disabled women are less likely to benefit from the scant, inadequate services that are available..." (Lang & Charowa, 2007, p. 7). Nevertheless, on 23 September, 2013, Zimbabwe made great strides towards recognising the rights of disabled people by becoming the 135th state party to duly ratify the UN Convention on the Rights of Persons with Disability, (CRPD) (United Nations, 2008) and its Optional Protocol (Mandipa & Manyatera, 2014). In addition, the crafting and enacting of the new Zimbabwe constitution which came into force in various stages in 2013 meant significant advancement towards expanding disability rights in the country (Government of Zimbabwe, 2013), albeit at policy level and not on the ground.

The disability movement in Zimbabwe is credited with the establishment of a total of 53 Disabled People's Organisations (DPOs) all operating under the canopy of the National Association of Societies for the Care of the Handicapped (NASCOH), (SIDA, 2012). However, such a large number of DPOs has not translated into a vibrant and effective disability movement (Lang & Charowa, 2007). Stuck in distinct functional pockets and scattered all over the nation, the DPOs do not speak with one voice. Furthermore, the DPOs function at a level of inadequate organisational capacity which results in an inevitable regression of disability sector activities. Consequently, the disability movement has not been successful in playing a leading role in lobbying and advocating for disability policy review, and neither has it been able to influence appropriate professional practice. It is therefore not surprising that the voice of disabled people, including that of disabled women, is a rare

feature in the country's research arena, thereby giving rise to the purpose and significance of this study.

1.2 Purpose and significance of the study

The purpose of this study was to explore within an African context the experiences of sexuality of disabled women in Zimbabwe. To the researcher's knowledge, this is the very first time that disabled women's life stories of sexuality are being subjected to narrative analysis in Zimbabwe. Compared to South Africa, where writings of disabled people's sexuality have begun to emerge from interviews and focus groups discussions (Bleazard, 2010; McKenzie, 2012), formal studies on disabled women's experiences of sexuality in Zimbabwe are non-existent. This study therefore presents original research on an issue that is not found in Zimbabwean research data. The research enhances the existing body of knowledge by making recommendations towards the development of a disability and sexuality framework that informs policy, and for practice by individuals, civil society, DPOs and practitioners among others. The study also makes a contribution to the development of indigenous theoretical formulations that are rooted in the African context, which arise from efforts that are made by this study to address the research problem that I outline below.

1.3 Research problem

As previously mentioned sexuality forms a core part of being human and it impacts on both the physical and mental health of all human beings (Ball, n.d.; Gomez, 2012). However, very little has been written about the experiences of sexuality of disabled women in both the Global North and the Global South, thereby exposing an analogous lack of interest on the subject, on the part of both global and local researchers (Abu-Habib, 1997). Most African publications on the subject of sexuality (Maticka-Tyndale, Tiemoko, & Makinwa-Adebusoye, 2007; Staples, 2006; Tamale, 2005, 2011) including those from Zimbabwe (Zinanga, 1996) have thus far not paid attention to the experiences of sexuality of disabled women. By facilitating the voice of disabled women in Zimbabwe through the exploration of disabled women's experiences of sexuality, this study sought to shift the experiences of sexuality of disabled women from the periphery of society to the fore, thereby answering the research question which is outlined below.

1.4 Research question

- How do disabled women in Zimbabwe experience their sexuality?

1.5 Research aim

In this study, I sought to conduct an in-depth exploration of the experiences of sexuality of disabled women in Zimbabwe. Through the facilitation of the voice of disabled women, the study explored the rich first-hand contribution that the women could make towards the understanding of their experiences of sexuality.

1.6 Research objectives

- To describe the experiences of sexuality of disabled women in Zimbabwe.
- To recognise the main aspects of context and culture that influence the experiences of sexuality of disabled women.
- To identify the influence of the intersection of various identity markers such as gender, culture and disability as well as power and privilege practices on the experiences of sexuality of disabled women.
- To contribute towards the development of indigenous disability and sexuality theoretical formulations that are rooted in the African context.

1.7 Outline of thesis chapters

Chapter 1 is an introductory chapter which identifies the knowledge gap in relation to the experiences of sexuality of disabled women in Zimbabwe. The chapter also outlines the context within which this study took place, the study's significance and purpose, the research problem, the research question and aim, as well as the objectives of the study.

Chapter 2 articulates the conceptual framework of this study which is anchored in critical feminist disability studies (FDS) as the overarching theoretical lens for the study. To enhance my exploration of the research problem, I draw from FDS views on the concepts of power and the body, given that sexuality interacts with such concepts in its behaviour. In addition, I examine the critical FDS perspectives of the intersectional model alongside an argument that

the experiences of sexuality of participants are shaped by a simultaneous interaction of various identity markers. Given the impact that the social model of disability has made in both the disability movement and disability studies thus far, I discuss the critical perspectives of FDS towards the model. Where relevant, I weave in colonial/post-colonial feminist perspectives in an effort to connect knowledge production to the vantage point of the post-colonial Zimbabwean disabled woman.

Chapter 3 encompasses a discussion of literature that is pertinent to this study. I start off by discussing the subject of sexuality with the aim of highlighting the gendered sexual behaviours that are common in Zimbabwe, and to later use such practices to analyse the experiences of sexuality of disabled women in the country. In addition, I examine the notion of gender based violence (GBV), on the basis that GBV is a phenomenon which is intertwined with sexuality and the patriarchal context of this study. I discuss the dominant discourses of disability in Zimbabwe, in an effort to highlight the contextual understanding of disability in the country and to ultimately analyse the link between such a conceptualisation with the experiences of sexuality of disabled women. In the final section of the chapter, I examine the sexuality of disabled women from an international perspective on the grounds that whilst it is critical to develop indigenous philosophies of African sexualities, African scholars can still reflect upon global concepts, ideologies and practices to allow a broader reflection on African sexualities.

Chapter 4 outlines the methodology which I followed in carrying out this research as well as my philosophical standpoint. In discussing the narrative methodology which underpins this study, I highlight the methodology's strengths and limitations. In addition, the process which I followed in inviting participants and the interview techniques of the Biographic Narrative Interpretive Method (BNIM) which I used to generate data are outlined. I explain my choice of data management techniques and the three levels of analysis that structure my approach to data analysis, namely 1) narrative analysis, 2) analysis of narratives, and 3) a deeper layer of analysis which is intertwined with the discussion of findings. I end the chapter with an assessment of issues of quality and validity that are pertinent to this study.

Chapter 5 presents four biographic narratives, which foreground the voice of participants, thereby illuminating the experiences of sexuality of participants who have different kinds of impairments: 1) Tsitsi has a polio induced physical impairment and she uses crutches; 2)

Nyarai has intellectual impairment; 3) Danai has albinism and visual impairment; and 4) Chipso has a spinal cord injury induced physical impairment and she uses a wheelchair. I felt that the presentation in this chapter of all the 16 biographic narratives that make up this study would stretch the thesis beyond its academic requirements. I therefore decided to present the four narratives that serve as robust examples of the processes of study. I produced the disabled women's stories using the narrative analysis approach, and I use pseudonyms that were chosen by the participants themselves to preserve their original identity.

Chapter 6 presents the four themes that emerged from a cross case-analysis of the 16 narratives that represent the entire data set of this study. I employed the analysis of narratives approach to generate such themes from the four stories which I presented in Chapter 5, as well as from the other 12 narratives that I did not include in the preceding chapters but which I have presented in synopsis form in Appendix 18. The themes are: 1) dynamic engagement in intimate partner relationships; 2) gender based violence (GBV); 3) matrimonial relationships; and 4) silences surrounding issues of sexuality.

Chapter 7 presents the discussion of findings which, as previously mentioned, is intertwined with a deeper layer of analysis which is interpretative in nature and which focuses on understanding the accounts of participants along four key findings: 1) disabled women are not passive recipients of disability stereotypes but they construct their own understanding of what it means to be disabled and sexual; 2) Participants attach value to heterosexual marriage; 3) The complex intersection of culture, disability and normative gender roles and power relations within heteronormative relationships contribute to the vulnerability of disabled women to inequitable, unsafe and coercive sexual practices which exacerbate the women's vulnerability to HIV infection; and 4) Disability, culture and the myth of asexuality intersect to create a lack of sexuality education for disabled girls and disabled women.

Chapter 8 presents the theoretical and methodological reflections of this study by first of all returning to the research question which frames the study. The chapter considers the suitability of the conceptual framework which informed the study as well as the appropriateness of the methodology which I applied in an effort to answer the research question. In addition, the chapter reflects on both the process as well as the significance of the study in relation to the contributions that it has made to the body of knowledge.

Chapter 9 enunciates the recommendations that arise from the findings of this study at various levels: policy, services, disabled women, DPOs and civil society. The chapter concludes the entire study and illuminates the possibility of undertaking further research in this understudied area mainly in the Global South and specifically in Africa. I present the conceptual framework that is guiding this study in the next chapter.

CHAPTER TWO

CONCEPTUAL FRAMEWORK

...people coming from different walks of life, watching the same event, are likely to come up with different interpretations of that event. Certainly, depending on “the spectacles” each one of them is “wearing” in viewing the event...Each person’s view-point, or point of reference, is his/her *conceptual...framework*. (Imenda, 2014, p. 185)

Introduction

When a researcher realizes that a problem cannot be significantly researched by using a single theory, the researcher may synthesise a number of related concepts in an effort to use such intergrated concepts to comprehensively understand a research problem (Imenda, 2014). In line with such an assertion as well as with the above quote I created a conceptual framework which integrates related theoretical concepts under an overarching critical feminist disability studies (FDS) lens. However, by drawing on such a lens which evidently arises from the Global North for use in an African study, I do not intend to promote Western theoretical ethnocentrism, but rather wish to mitigate the scarcity of contextual theoretical perspectives on the subject. I argue that different cultures in different parts of the world deserve respect; hence in the subsequent analysis of this study, I seek to pay adequate attention to the indigenous socio-cultural value systems of the context of this study.

Whilst disability studies have examined the identity marker of disability in pursuance of an understanding and total inclusion of disabled people in society (Garland-Thomson, 2011), the mainstream feminist discourse has sought to expand our understanding of the category “woman” (Garland-Thomson, 2005, 2011; Lewis & Mills, 2003). That is not to say that FDS becomes a simple combination of feminism and disability studies, but with its critical edge and transformative potential FDS facilitate the re-imagining of disability (Garland-Thomson, 2005) as well as the re-imagining of gender (Hall, 2011). As such, FDS does not just add the experiences of disabled women to feminist literature or to disability studies, but it modifies

both fields as it seeks to deepen the feminist analyses of disability, body politics, oppression, interdependency and agency (Erevelles, 2011; Garland-Thomson, 2005) as well as embracing different sexual orientations.

As I mentioned in Chapter 1 and in line with FDS, this study was open to disabled women of all sexual orientations. I take cognisance of the significant gender debates in which some leading feminist scholars (Butler, 1990; Meekosha, 2004) have pointed at varied sexual orientations such as trans-genders, lesbians and gays and noted that gender is an unstable and fluid fiction which changes periodically within varying contexts. However, as noted in the previous chapter, the majority of African people in Zimbabwe denounce different sexual orientations other than heterosexuality. In Zimbabwe, homosexuality is branded a White man's "disease" or in some instances it is linked to witchcraft and evil spirits that should be dealt with privately and at family level (Epprecht, 1998). In addition, the legal prohibition of same sex marriages by the constitution of Zimbabwe (Government of Zimbabwe, 2013) means that the diversity of sexual orientations has not been officially accepted in Zimbabwe. The same perspectives towards sexual orientation are found in other African countries such as Uganda and Namibia (Epprecht, 1998). Nevertheless, such standpoints may have a bearing on disability studies, thereby influencing the heterosexual ambiances that may reflect in the individual experiences of sexuality of disabled women in the context of this study.

In the section that follows, I introduce critical FDS as the overarching lens of the conceptual framework that guides this study. I then discuss the concept of sexuality, whilst examining its link with the body and power, given that sexuality is functionally interconnected with such concepts. In addition, I examine the intersectional model within a critical FDS framework, on the grounds that the experiences of sexuality of disabled women are shaped in the context of multiple identity markers. Furthermore, I discuss the critical perspectives of FDS towards the social model of disability; a model which has thus far had a great impact in the field of disability studies. Where relevant, I weave in colonial/post-colonial feminist perspectives in an effort to connect knowledge production to the vantage point of the post-colonial Zimbabwean disabled woman. Below, I introduce critical FDS as the overarching lens of the conceptual framework that guides this study.

2.1 Critical feminist disability studies

Critical FDS seeks to understand disability from a gender point of view (Meekosha, 2004), following the mainstream feminist marginalisation of disabled women's experiences. Several disabled feminist advocates in the Global South contested the masculine structure of both disability studies and the disability movement (Meekosha & Shuttleworth, 2009), in which the voice of disabled women has been evidently missing. In addition, FDS scholars argued that the experiences of disabled women within heteronormative contexts differ in relation to issues such as menstruation, reproduction, abortion, child-rearing and sterilisation among others. A key argument of FDS is that disability is a social construction of "Other" in relation to societal norms which fail to embrace disability as human diversity but which relegate disability to a category of inferiority (Garland-Thomson, 2005), in contexts which are described by Chouinard (1997) as ableist societies and environments.

Ableist settings are characterised by thoughts, customs, organisations and social relations that assume able-bodiedness, thereby constructing disabled people as "others" who are generally ignored and treated as sub-standard by society in contexts where disability is a product of power relations (Chouinard, 1997). By interrogating the belief that disability is a defect, a deficiency or a surplus, the critical perspectives of FDS do not delineate disability as a flaw that is integral to certain brains or bodies, but they perceive disability as a system of denigrating or ignoring certain bodies (Garland-Thomson, 2005). Viewed from such a lens, disability is a way in which people think about bodies and not anything that is really faulty with bodies (Malmberg, 2009). For example, people may think that all people who are visually impaired are so "damaged" that they do not want to have sex, yet the reverse may be true. However, (Garland-Thomson, 2011) notes that such perspectives permeate cultures and authenticate inequalities in the distribution of status, capital and power.

The above discussion resonates with what Garland-Thomson (2011) calls the ability/disability system which differentiates and marks bodies by using ideologies. However, instead of focusing on precise forms of disability and how such bodies behave, FDS concentrates on probing the types of meaning that are assigned to the bodies (Garland-Thomson, 2005). The same author states that as FDS moves towards inclusion from exclusion, the approach seeks to rescue silenced voices and experiences that have not been properly represented, thereby facilitating the accommodation of bodies instead of the

condemnation of them. Whilst the mainstream feminist discourse has generally viewed disabled women as women with individual “tragedies” that require private personal attention, charity or care (Price, 2011), Garland-Thomson (2005) states that FDS challenges the perception that disabled women are sub-standard, deficient, excessive, incompetent, unhealthy and useless.

As the critical concepts of FDS explore the relationship between gender and disability, the studies hold the potential to facilitate the reimagining of both disability and gender and what it means to have a different and dynamic body which is constantly interfacing with the environment from both a social and material perspective (Garland-Thomson, 2005; Hall, 2011). Such reimagining, for example, is illuminated by an analysis of the debatable issue of two White lesbians in the US, who are Deaf and who also desire to have a Deaf child (Kafer, 2011). Controversy arises because conventional traditions view Deafness as a health problem which requires either a total elimination or at least an improvement and heterosexuality is viewed as the legitimate sexual orientation. However, the narrative of the lesbians represents a resistance to non-disabled heterosexuality, thereby showing that being queer and being disabled may actually turn out to be qualities that are desired by people who embrace their bodies with pride. The narrative therefore challenges the dominant heterosexual and non-disabled ideologies about sexuality, in a scenario where the suppressed voice of disabled women of unconventional sexual orientations may begin to be heard.

As noted by Hamilton (2012), and similar to other conceptual models, one cannot say that the compact base of high quality cross-genre writings in the leading FDS collection (Hall, 2011) is a perfect compilation. Whilst I acknowledge that Erevelles (2011) reflects on the intersection of war, race, gender and disability in the third world, I also argue that the excellent work excludes perspectives from the Global South, particularly from Africa. Such a situation marginalizes the viewpoints of theorists and researchers in Global Southern contexts and it suppresses the voice of disabled African women including those of non-normative sexual orientations. The scenario could be traced back to the 1960s when, as noted by Hooks (1981), the mainstream feminist discourse was condemned for ignoring the voice of Black feminists, thereby neglecting the complexity of the experiences of lower class, poor, non-heterosexual and non-White women, leading to the withdrawal of Black feminists from active participation in the mainstream feminist discourse. Along the same vein, FDS “...falls prey to its own critique of normativity by failing to seriously engage ‘difference’ along the axes of

race, class, ethnicity, sexuality, and nationality” (Erevelles, 2011, p. 119). Perhaps it is time for FDS to create space for the voice of disabled Black women in the Global South, and particularly in Africa, to be heard, thereby enabling the wholesome success of the transformative FDS. However, within FDS lies the subject of sexuality and the body, which I discuss below, on the grounds that there is an intricate connection between sexuality and the body which makes it impossible to divorce the two concepts from each other.

2.1.1 Sexuality and the body within a critical FDS framework

In this section, I discuss the viewpoints of sexuality and the body under an overarching critical FDS conceptual framework, given that as previously mentioned sexuality connects with the body in its behaviour. There is a common prevalence of the hypothesis that disabled people are asexual beings who, due to their bodily differences, do not require any form of acknowledgement in the arena of sexuality (Lloyd, 2001; Ghai, 2002; Malmberg, 2009). In relation to normative feminine perspectives, disabled women are not only mythically considered as asexual but they are also regarded as unattractive and unbefitting as parents (Garland-Thomson, 2005; Lloyd, 2001). The issue of the normate as constructed by Garland-Thomson (1997) therefore comes to the fore; the concept symbolises a construction of an identity by those who consider themselves to be “normal” enough in relation to their bodily features and capital. The normate assumes that disability erases all the other qualities of a human being, thereby reducing the complex being to a single social life attribute such as disability, at the express exclusion of all of an individual’s other identity markers such as sexuality, class, gender or culture.

The normate’s framing of “normalcy” assigns disabled women to an asexual status on the grounds of their bodily impairments thereby denying disabled women the right to intimate relationships, personal satisfaction, marital unions and motherhood (Lloyd, 2001). From a critical FDS perspective, Wilkerson (2011) proclaims that the sexuality of “othered” people is usually regarded as a social problem, a practice which in itself is a symbol of oppression. In addition, “othered” groups often confront coercion, limitation, and punishments, and they are often denied access to significant information that is relevant to their sexuality in contexts where bodily perfection is linked to sexuality. When the body is regarded as the conduit between sexuality and sexual roles, the position of disabled women in non-normative body images may weaken their case of being perceived as sexual beings, particularly in

reproduction where they are expected to prove that they are functionally capable (Lloyd, 2001). From a FDS perspective Wilkerson (2011) calls upon society to bear witness to practices that undermine the sexuality of oppressed people, including practices that involve medical personnel, and to intercede in such practices. Whilst such an approach may be practical in some contexts, I argue that the approach could be problematic in some settings where the people who are supposed to intervene are the same people who facilitate the perpetuation of practices of marginalisation due to a lack of awareness or understanding of disability and sexuality issues, as further discussed below.

It is common for some people in different societies across the world to fallaciously believe that all incapacities of disabled women are biological, that they have no sexual feelings and that they will produce defective children (Banks & Kaschak, 2003). Disabled women who live in institutions are worse off, as they are likely to experience a loss of their sexual agency due to a lack of privacy which prevails in residential institutions (Wilkerson, 2011). Living under the watchful eye of institutional staff, disabled people who may have met at an institution and fallen in love are forced to meet in communal areas such as dining halls where every other person can hear even that which they whisper to each other (Ball, n.d.). From a FDS perspective, Wilkerson (2011) states that there is need to understand sexual agency as a significant part of the liberation struggles of all marginalized groups including disabled women and poor people.

2.1.2 Critical FDS perspectives of power and the body

In this section I discuss issues relating to power and the body, on the grounds that sexual behaviours interact with the body within contexts of varying social patterns of power. From a FDS viewpoint, Hall (2011) argues against the notion of using bodily impairment as a measure of quality of life or the determination of whether a life is worth living or not. In addition, Garland-Thomson (1997) argues that there is no standard way of defining what it means to be “normal” and whilst some people may epitomize themselves as “ideal” human beings, the reality is that very few, if any people, can actually fit into the mould of the normate. A normative human being as illustrated by Goffman (cited in Garland-Thomson, 1997, p. 8), is one who is among other things “...a young, married, white, urban, northern, heterosexual...of good complexion, weight and height...”. Garland-Thomson notes that such a construction of “normalcy” is devoid of women, thereby relegating women to a location of

“invisibility” on the grounds of gender. One is therefore left to wonder about the location of disabled women, and in particular, Black African disabled women.

In line with the above discussion, Hall (2011) states that FDS constructs disability as an outcome of power relations in which the body, body differences and issues of normalcy are key to the analyses of all kinds of oppression. The practice of classifying bodies as either “normal” or deviant is entrenched with facets of power, where bodily functions are outlined in relation to the normate’s framing of bodies (Malmberg, 2009). At the heart of such deliberations of classification are ideologies of what has been named “able-ism” (the idea of being able in a mental, physical and intellectual way) as well as the idea of being disabled in cases where one is perceived to be lacking in any or all of these diverse abilities (Hanna & Rogovsky, 1991). It therefore follows that those who do not have impairments often have the power to define the norm under which some bodies are regarded as normal, and others are considered as “the other” or deviants from the norm.

The views of the normate serve to, among other things: silence the voice of disabled women in a context where the notion of the whole body turns into a marker which separates people from one another, within frameworks of the fluid concepts of “normalcy” and “deviancy” (Malmberg, 2009). The same author states that the idea of the body classifies people in a scenario where the disabled are relegated to locations where they become subordinate and vulnerable “objects”, in practices where norms, perspectives and ideologies frame bodies that have impairments. Such perspectives concur with the normate’s viewpoints upon which some people assume that they can take positions of authority and exercise the power that such positions award them to frame what they call “norms” (Garland-Thomson, 1997). The same author notes that the normate is so powerful that people may perpetually try to fit into the normate’s mould in the same way that Cinderella’s step-sisters attempted to compress their feet so that they fit into Cinderella’s slipper.

The concept of norms is also described by Malmberg (2009) as “bodynormativity”, a term which refers to a body which from both a mental and physical perspective is perceived as “normal” and complete. To further illustrate such perspectives, I use the event of the Ashley treatment:

In January 2007 mainstream U.S. media headlines broke the story of the “Pillow Angel.” Readers learned the “Pillow Angel” was Ashley, a disabled girl whose parents in 2004 had obtained approval from doctors and the ethics committee at the Seattle Children’s Hospital to pursue medical treatment that would stop her growth and sexual development. Asserting that Ashley would always have the motor and cognitive skills of a three-month-old baby, those who supported this treatment claimed the treatment would improve her quality of life by preventing future discomfort and trauma and by making it easier for her parents to take care of her. (Hall, 2011, p. 1)

At the time that the medical procedure was undertaken, Ashley was six years old, and the procedure consisted of a hysterectomy which would ensure that, among other things, Ashley would not be able to menstruate or to get pregnant (Hall, 2011). The treatment would also see the elimination of her breast buds so that she would not be able to develop the breasts of an adult female. Her parents justified the treatment as essential on the grounds that Ashley’s non-development of features that symbolise adult femininity on her body would among other things be less stressful for her. Ashley would not have to deal with the trauma of having a baby’s mind in a full grown woman’s body; critics argued that the treatment represented a form of gendered oppression.

An analysis of the Ashley treatment provides evidence of the extent to which the normate can control the sexuality and sexual development of disabled girls and women. The belief that disabled people are not sexual beings or that they are hypersexual is a form of disability oppression which may have been used by Ashley’s parents, doctors and other proponents to justify the Ashley treatment (Hall, 2011). Feminists have been condemned for their failure to express outrage at the Ashley treatment, which from a FDS perspective, is an example of modern eugenic treatment of disabled females (Lamp & Cleigh, 2011). However, Ashley’s father and mother as well as the medical team that undertook the surgery defended their actions, in a scenario in which they appear to be unable to come to terms with the fact that a disabled girl or woman is a sexual being (Hall, 2011). It is evident that the growth and development of the normate is assumed to be the only way that should determine the way in which every other human being should grow. The frameworks of the fluid concepts of “normalcy” and “deviancy” can therefore serve to control the sexuality of disabled girls and disabled women in ways which medicine is also actively involved in.

By creating disease classifications, medicine was able to attain the power to define what is “normal” and what is “deviant”, and in so doing it creates disease – thereby prohibiting certain practices and making others possible (Pylypa, 1998). Within such a medical context, doctors regard disability as a person’s withdrawal from biological norms of the body and the doctors perceive social practices as an unavoidable outcome of biological bodily impairments (Wilkerson, 2011). From a FDS perspective Wilkerson cites instances in which the medical fraternity has used its power to prescribe the “inappropriateness” of the sexuality of disabled women. Such examples include one in which women who are disabled with spinal cord injury are denied access to birth control medical drugs by healthcare staff, in a scenario which implies that the women have reached the near end of their lives because of the impairment. However, regarded as a solid base of truth and personifying the healing front of technology and science, medicine is believed to be absolutely genuine.

The medical discourse is rarely questioned; because once a bodily status has been certified by the medical fraternity as being sub-standard, people seldom query such certification (Wilkerson, 2011). The general belief is that medical proclamations are absolutely objective and are separate from emotions, beliefs and specific human concerns. Excessive emphasis is placed on the medical diagnoses and yet, the understanding of disability requires much more than clinical “facts” about the body; albeit the necessity of such “facts” in determining medicinal remedies in cases where they are required (Brisenden, 1986). The same author states that the problem arises when the power of medicine goes beyond the prescription of medicine (in cases where medicine is required), and frames the manner in which people should live their lives. Fegan, Rauch, and McCarthy, cited in Wilkerson (2011), give the example of a couple that was given permission by medical doctors to marry, but was directed not to have sex, in a context where medicine becomes an authorising practice.

The irony of the matter is that medicine derives its power from exercising measurements that come to be seen as the same as biology (Pylypa, 1998). The power of medicine therefore lies in constructing numerical measures against which all human beings could be adjudged, thereby representing an official process of disciplining and controlling the body so that it maintains a certain standard of “normalcy”. However, practices of normalisation breed control in all facets of life, thereby putting people under pressure to make an effort to conform to such norms. The practices also resonate with the concept of the normate, under

which the desire to conform to bodily characteristics that are emulated by the normate highlights the fact that people in most societies perceive impairment as undesirable.

Michel Foucault, who was politically affiliated with the concerns of minorities such as those with psychosocial illnesses, homosexuals and prisoners, came up with a novel conceptualisation of power, which rejects models which associate power with dominance, control and coercion (Foucault, 1976; Turner, 2002). Foucault proclaims that power is knowledge in the sense that power/knowledge is exercised to delineate what is possible or not possible to do, thereby making it only feasible to act in certain ways of knowing and impossible to act in others (Foucault, 1976; Pylypa, 1998). As such, power functions on people's own bodies, in simultaneity with desire and knowledge. According to Foucault (1976), all that science does is to produce knowledge which generates the discourse of normality and norms, upon which disciplinary power arises.

Disciplinary power is characterised by systems which entail minute activities of managing the body which not only create knowledge about the body but which also depend on the knowledge that is created about the targeted group (Pylypa, 1998). For example, the Western feminine desire of slenderness and “appropriate” health represents disciplinary practices that arise from a power/knowledge nexus, as identities are constantly created and managed within a context of knowledge creation and disciplinary power. One can therefore state that from a critical FDS perspective, the pregnancy of a woman who is disabled with dwarfism for example, may be met with abhorrence as it inevitably threatens the knowledge that is created by the medical sector in the formulation of identities of sexuality which are based on ableism. However, Pylypa (1998) highlights instances of resistance that have been recorded in the US where in the 1990s women advocated for the achievement of control over their own bodies and births that involve less machinery and tools and alternative birth settings.

The discourse of disciplinary power restricts disabled people in ways that open certain ways of acting (norms) whilst making other forms of acting impossible (Foucault, 1976; Pylypa, 1998). People who find themselves falling outside of such norms are beset with disciplinary approaches that are aimed at eliminating their “abnormality”. In line with such an assertion, Foucault (1976) states that people are involved in creating their own surveillance, within systems of daily behaviours and traditions such as the self-regulation of sexuality, health and hygiene. It therefore follows that power occurs at micro-levels of people's daily lives, as it

permeates all levels of society, intertwined in complex webs of social relationships, practices, organisations and machineries. Drawing from Foucault's perspectives, "...power is rather like a colour dye diffused through the entire social structure and is embedded in daily practices..." (Foucault, in Turner, 2002, p. xii). Power is therefore everywhere and it is diffused through discourse and social practices, and it permeates everyday spaces.

From a critical FDS standpoint, one could argue that the sexist nature of the society in which both disabled women and non-disabled women live generates the kind of knowledge that frames the type of appearance that women seek to have (Morris, 2001). A disabled woman may begin to believe that she is ugly to the extent that she will not be able to undress in front of others or her husband and she may even despise her own body. Such situations may arise when a woman judges her own body in accordance with the normate template of attractiveness, thereby derailing her own self-esteem and sexual confidence (Malmberg 2009). In such a context the woman feels that she has to hide her body which she views as one that is missing the mark of established standards of beauty (Saxton 1985). Furthermore, in the Global North, disabled women are constantly being bombarded with media messages that encourage them to buy products that alter certain aspects of their appearance so that their bodies may conform to established societal standards. Within African contexts, including in Zimbabwe, feminine beauty is framed around the notion of being a huge and plump non-disabled woman (Makinwa-Adebusoye & Tiemoko, 2007). However, from a Global Northern perspective, Malmberg (2009) states that some disabled women claim their agency and persistently fight against discrimination by keeping themselves clean, wearing make-up and shaving their legs to enhance their attractiveness. I use such perspectives in conjunction with Foucault's ideologies on disciplinary power, to examine the extent to which disabled women in this study are able to claim their agency, albeit within their African context.

Foucault's perspectives of disciplinary power are useful in examining the way in which disabled women perceive their bodily impairments, in a context where in accordance with Global Northern perspectives disabled women's behaviours and bodily appearances are policed by males (Morris, 2001), government statisticians and medical doctors (Pylypa, 1998). I use such viewpoints of disciplinary power to examine the way in which the sexual behaviours and bodies of disabled women in Zimbabwe are policed by various structures within the women's cultural context and the ways in which the women claim their agency. However, in resonance with an assertion made by Pylypa (1998), I note that Foucault's

conceptualisation of power has been criticised of being devoid of personal agency and advancing the notion of a passive receipt of norms by all people.

The argument is that different people respond differently to the knowledge that is generated by science, and different sub-groups within a society do not perceive social norms in the same way, and neither do they abide by such norms in similar ways (Pylypa, 1998). Foucault's theory has also been criticised for obstructing social change because the "disappearance" of power within his ideologies will complicate the process of locating domination and organising for its defeat. However, I concur with Pylypa, who states that Foucault's model complements rather than replaces the conceptualisation of power which is dominant and powerful. Whichever way, Foucault's concept of disciplinary power makes a significant contribution to our comprehension of the complications that surround the functions of power in a multifaceted way. In relation to this study, I note that such complexities occur in a context of intersecting social life attributes that influence the experiences of sexuality of disabled women as discussed below.

2.1.3 Critical FDS perspectives of intersectionality

In this section I draw on FDS perspectives of the intersectional model which I use to explore the sexuality of disabled women in Zimbabwe, through an examination of the intersection of the various identity-markers that influence the experiences of sexuality of the women. The perspectives of FDS begin with the supposition that disability is always intimately connected to other identity markers such as race, gender, sexuality and class (Syracuse University, n.d.). By eliminating the practice of assigning experiences to exclusively individual identity categories, intersectionality seeks to broaden and enrich social justice policies and interventions (Crenshaw 1989; Crenshaw & Harris, 2009). The objective is to promote possible collective action in an effort to bring those who are at the margins to the centre, in a scenario where: "When they enter, we all enter..." (Crenshaw, 1989, p. 167).

The term "intersectionality" was introduced by law professor Kimberlé Crenshaw in 1989 in an effort to evade the challenges that are embedded in identity politics (Crenshaw, 1989; Jordan-Zachery, 2007). Intersectionality considers the identities and experiences of people without assigning them to permanent categories (Simpson, 2009). Such classifications are metaphorically described by Sims (2009) as the placing of people in specific "boxes", when

in fact most people are reluctant to be put in “boxes” or to check “boxes” to denote their identity. Before the introduction of the concept of intersectionality, scholars had been trying to ascertain which among the various social attributes such as class, sex, or gender was more significant than the other (Beard, 1999). As a result, it was not uncommon to find that the fight against one manifestation of a social life attribute would worsen the disunions in the others. Intersectionality therefore became a dominant ideology of feminist thinking as well as the most expedient instrument in the tool box that is used by feminists to produce knowledge (Lewis, 2013), through highlighting the intersection of different identity markers but also addressing the notion of difference.

As mentioned above, apart from illuminating the intersection of multiple identities in framing people’s experiences, the other function of intersectionality is that it deals with the notion of difference (Shields, 2008). The second wave of feminism started in the 1960s in the US and spread throughout the world, as women campaigned against gender inequalities in various areas that included reproduction and the workplace (Baxandall & Gordon, 2002). Such a wave was also characterised with its feminist unit slogan “sisterhood is powerful” (Rampton, 2015), or “sisterhood is global” (Lewis & Mills, 2003) which purported that all women are the same and that they share similar narratives of lived experiences and oppression (Grey, 2004). In addition, the writings of Global Northern feminist theorists perceived women in the Global South as a homogenous group and made extensive generalisations about such women (Lewis and Mills, 2003). From a FDS vantage point Erevelles (2011) advances the question of the specific spaces within which disabled women in the Global South can claim their “sisterhood”. From an angle of race, Crenshaw raises the question:

...how can the claims that “women are”, “women believe” and “women need” be made when such claims are inapplicable or unresponsive to the needs, interests and experiences of Black women? (Crenshaw, 1989, p. 154)

An inability to examine difference in relation to the complex intersections of various social life attributes in different contexts runs the risk of rendering feminism irrelevant to oppressed and marginalised groups of women (Sa’ar, 2005). Different social life attributes intersect in diverse ways in divergent contexts to influence the experiences of sexuality of disabled women. The reality is that the lives of Global Southern women, including African women, have been intensely affected by colonisation, and a presence of the colonial legacy in the

lives of such women has continued to prevail (Holmes, 2007; Walters, 2005). An analysis of the contextual intersection of different social life attributes is therefore necessary, because various identity markers do not create similar kinds of marginalisation, discrimination and oppression for all women in all places in the world.

I concur with the FDS perspectives which, as stated by Syracuse University (n.d.), seek the inclusion of disability in feminist intersectional analyses and I also argue that not all disabled people experience disability and sexuality in similar ways. As such, paying attention to the political, economic and social contexts within which the intersectional experiences of disability take place is beneficial. For example, the colonial processes of powerful nations such as the USA, England, Portugal and Spain left a trail of dependency, poverty and disability in Global Southern countries (Meekosha, 2011). Whilst for example, disabling diseases such as polio have been eliminated in nations of the Global North, such diseases have remained prevalent in some Global Southern countries, where the impairing outcome of sub-standard drugs that are received from powerful nations have also been reported (Meekosha, 2011). Furthermore, the majority of people in colonised African countries and in other developing nations are unable to afford HIV drugs and assistive devices, in spite of the fact that disabled people who live in the Global South are expected to buy services and goods that come from powerful nations of the Global North.

Considering the above situation, it is not surprising that the discussion of a disabled identity, as advanced by Garland-Thomson (2005) in FDS, has come under criticism for explaining that disability is the most widespread human condition, which is interconnected with an individual's personification, life, character, and a manner of interacting with the universe. Erevelles (2011) argues that whilst Garland-Thomson (2005) has primarily challenged the feminist perspectives of the ab/normal body, her argument rests on a presumption that disabled identity is not a part of social, economic and historical settings. The same author raises the question, "How can acquiring a disability be celebrated as 'the most universal of human conditions' if it is acquired under the oppressive conditions of poverty, economic exploitation, police brutality, neo-colonial violence, and lack of access to adequate health care and education?" (Erevelles, 2011, p.119). Erevelles (2011) points out that FDS has not provided adequate answers to this and other questions that seek to address the ways in which distance could be negotiated in an effort to build unity across difference within the contemporary context of global capitalism.

In the context of the Global South, where national economies are characterised with economic poverty, the identity markers of disability and poverty are closely interrelated (Goodley, 2013; Meekosha, 2011) in framing the experiences of sexuality of disabled women. As poverty intersects with other identity markers, it becomes difficult for African citizens to obtain basic provisions such as water, foodstuff, health facilities and schooling (Jauch, 2012). There is widespread agreement that one must always take into consideration the multiple dimensions of oppression, least one risks assuming that all women are White or people of colour are male or that every other person is heterosexual (Risman, 2004). As such, different settings breed different challenges and responses even within the same broad band of issues (Gunjate & Shivaj, 2012). In relation to this study, I therefore argue that the facilitation of the voice of disabled women in Zimbabwe in an effort to explore the experiences of sexuality of the women within their own context is likely to make a significant contribution to the body of knowledge.

As is common with all theoretical concepts, intersectionality has been subjected to its own critique. Amidst the ongoing debates among feminist theorists, intersectionality has been criticised for its imprecision and open-endedness (Davis, 2008). As such, some theorists have argued that the model ought to have a clear set of defined boundaries in relation to what social life attributes it should encompass and that which it should not. Other scholars have criticised intersectionality for its lack of a methodology which could have possibly eradicated the “confusion” that abounds the model among researchers. However, I concur with Davis (2008) that the ambiguity and integral open-endedness of intersectionality instigates an endless discovery process which yields novel, broader and significant insights.

Intersectionality does not produce a normative straitjacket for monitoring feminist inquiry in search of the “correct line”. Instead it encourages each feminist scholar to engage critically with her own assumptions in the interests of reflexive, critical, and accountable feminist inquiry. (Davis, 2008, p. 79)

However, considering that the concept of intersectionality arose from Black feminists who were primarily concerned with issues of gender, race and class, the risk that such scholars may continue to be devoted to the examination of such identity markers at the neglect of other social life attributes has been noted (Meekosha & Shuttleworth, 2009; Sims, 2009). In attempting to mitigate such a risk, this study acknowledges that whilst it is important to

include these three identity markers in the discourse, it is also essential to ensure that people's numerous other social life attributes such as disability are not marginalised. It appears that the initial use of the intersectional model to address racial and gender inequalities in work place environments resulted in its neglect of issues such as disability and sexuality (Sims, 2009). However, the notation of intersectionality is entrenched in critical FDS thereby permitting a multifaceted analysis of disabled women's oppressions, which could be further enhanced by drawing FDS perspectives of the social model of disability, as discussed below.

2.1.4 Critical FDS perspectives of the social model of disability

In this section, I introduce the social model of disability as well as discuss the critical perspectives of FDS towards the model. Bearing in mind that the social model of disability has thus far made a great impact in the field of disability studies, to the extent where it has been described as standard learning in the field (Samaha, 2007), my aim is to discuss the tenets of the model in an effort to illuminate its relevance to the sexuality of disabled women in Zimbabwe. I therefore examine the level of the model's attentiveness to the subjects of sexuality, gender and culture given the fact that sexuality forms a core part of being human; gender vividly illuminates the concerns of disabled people and different societies have different ways of conceptualising disability, influenced at most by their cultural belief systems.

The social model of disability was formulated in the 1970s by a small group of activists from the British Union of Physically Impaired against Segregation (UPIAS) (Hammell, 2006; Shakespeare, 2006, 2013). Disability activists were challenging the dominance of the medical model of disability whose focus was on the biological nature of impairments. The medical model advanced the argument that failure to obtain a cure would narrow or eliminate a disabled person's chances of earning full social inclusion (Ghai, 2002; Hammell, 2006; Harris & Enfield, 2003), thereby relegating the disabled individual to being an object of charity. Contrary to such a perspective, the social model proclaimed that the answer to the disability problem did not lie in the narrow medical curing of impairment, but from attaining change at family, community and societal levels, given that disabled people live within those social organisations (Harris & Enfield, 2003). From such a point of view, the exclusion of disabled people from complete participation in all aspects of social life was deemed as preventable, and not as an unavoidable outcome of impairment as advanced by the medical

model of disability. Such a perspective concurs with the viewpoints of FDS, which argue that disability is the way in which society interprets human differences and is not a disease that should be cured (Garland-Thomson, 2005). However, the development of the social model resulted in the moving of disability from the traditional medical landscape to a new socially oriented territory, albeit in a Global Northern context, as discussed below.

The social model of disability is an urban model of disability which was crafted and upheld by disability theorists who live in urban settings of the Global North (Hammell, 2006). Whilst I embrace the emancipatory and participatory tenets of the social model, I question its applicability in the Global South, and particularly in an African rural context. Hammell states that the real experiences of disability in the rural Global South are characterised by among other things, unpaved roads, mountains, sand, hills, rough ground and mud. Of notable concern is that the majority of disabled women live in the Global South and they belong to an underprivileged status, which results in the women having limited choices in relation to where and how they can live (Avery, 1994). Thomas (2006) points at underprivileged disabled people in poor nations, and argues that they are contextually disadvantaged at both economic and social levels to the extent that perhaps all they ever know about is material lack. Oblivious of such perspectives, the 1976 UPIAS policy statement cited among other things, staircases, outdated disability aids and kits, and inflexible factory and office working patterns as some of the key challenges faced by disabled people (Shakespeare, 2013). The barriers presented by such challenges in the Global North may be different from those that are confronted by disabled people in the Global South, particularly in African contexts.

As discussed in Chapter 1, the social model of disability has been credited with facilitating the disability movement's focus on issues such as housing, transportation, education and employment (Shakespeare, 2000), but it has neglected issues of sexuality. Yet, in a list of priorities, disabled people would prioritise the development and sustenance of reciprocal intimate partner relationships compared to, for example, pursuing transport issues (Waxman, 1989). Whilst disability may be a strong social life attribute which is capable of edifying others (Shakespeare, 1996) sexuality or gender may be more significant to some people than disability. By focusing on disability and ignoring other identity markers such as gender and sexuality, the social model privileges disability at the expense of other social life attributes. Yet, most disabled people feel that sexuality is a key area of their concern, "We are more concerned with being loved and finding sexual fulfilment than getting on a bus" (Waxman &

Finger, 1989, p. 2). As discussed in section 2.1.3, the reality is that a person's life world cannot be wholly framed and understood by using a single characteristic of his or her identity.

Disabled women are quickly assigned to an asexual status and are denied the right to "sexual intimacy, love, marriage, motherhood and personal fulfilment" (Boylan, 1991, p. 23), resulting in the silencing of their voice in the zone of sexuality. This is in spite of the fact that the UN Convention on the Rights of Persons with Disability (United Nations, 2008), Article 6:1, directs State Parties to "...recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms." Morris (2001) calls upon society to come to terms with the fact that disabled people have a right to life, hence they should be allowed access to relevant entitlements, not only because they are human beings but because they are equal citizens. In any case and as noted in Chapter 1, sexuality forms a core part of being human and it impacts on both the physical and mental well-being of all human beings (Gomez, 2012). I would therefore suggest a social model of disability which addresses the subject of sexuality seriously, albeit within an intersectional framework.

On another note, I question the social model's over-emphasis on the subject of barriers and its apparent avoidance of cultural issues. As previously mentioned, I argue that the recognition that societies have different ways of conceptualising disability, influenced at most by their cultural belief systems, is of paramount importance. For example, some African communities believe that the reason why some children are born with albinism is because their mothers had sex with a White man or a ghost (Haihambo & Lightfoot, 2010). Whilst such perspectives may fit in with the barriers that are cited by the social model of disability, it is evident that these kinds of barriers become contextually different. The significance of culture in the social model of disability could therefore be reinforced by an illumination of the fact that central ideologies of any given culture are constructed in such a manner that they end up becoming what Hammell (2006) calls "common sense", "natural" and "normal". Such normative cultural "scripts" influence the beliefs that inform people's behaviours and the manner in which they conduct themselves.

In spite of its flaws, the social model of disability has been progressive in directing attention from the personal to the political, in giving rise to the disability movement, discouraging a negative disability identity as well as in directing civil rights legislation and illuminating and

promoting the removal of barriers (Oliver, 1996; Shakespeare, 2006). In particular, the gains of the social model worldwide have been noted in the passing of legislation which prohibits discrimination on the grounds of impairment, particularly in the work place and the transport sector (Winter, 2003; Thomas, 2006) and in some instances in housing and education. However, such laws need both appropriate interpretation and enforcement if at all they are to be meaningful (Winter, 2003). In addition, Thomas (2006) asserts that the acknowledgement of the worldwide progress that has been made by the social model of disability does not conceal the huge amount of work that still needs to be done if the full equality and inclusion of disabled people is to be achieved, particularly in the Global South.

I end this section by saying that the critique of the social model which I articulate above is not meant to stretch the model to levels that are beyond its capacity (Oliver, 1996). In any case, I take cognisance of the assertion made by Oliver that the social model was never meant to stand in the place of an all-encompassing social theory, but instead it was aimed at garnering collective political action in the hope of inspiring professional related practice. However, I argue that if the social model is founded on such goals, then its indifference to the intersection of social life attributes such as sexuality, gender and culture can only serve to narrow its effectiveness and impact in wider contexts, particularly in Africa. A model which claims to shape disabled people's experiences and to make them masters of their own destinies should sufficiently attend to the main concerns of all people with disabilities (Lloyd, 2001), including those of disabled women.

Conclusion

In this chapter, I introduced critical FDS as the overarching lens for the conceptual framework that guides this study. I discussed the concept of sexuality, whilst examining its link with the body and power, given that sexuality interacts with such concepts in its behaviour. In addition, I examined the intersectional model within a critical FDS framework, on the grounds that the experiences of sexuality of disabled women are shaped by multiple identity markers and the model also addresses the notion of difference. Furthermore, I discussed the critical perspectives of FDS towards the social model of disability in an effort to illuminate the model's relevance to the experiences of sexuality of disabled women in Zimbabwe. Where possible, I wove in colonial/post-colonial perspectives in an effort to connect knowledge production to the positionality of the post-colonial Zimbabwean disabled

woman. However, closely linked to the conceptual framework of this study is the literature review that guides this study, which I discuss in the following chapter.

CHAPTER THREE

LITERATURE REVIEW

Introduction

In the previous chapter I examined the theoretical concepts that are relevant to this study under an overarching critical FDS lens, which I use to explore the experiences of sexuality of disabled women in Zimbabwe. In this chapter, I present an in-depth review of literature which seeks to examine the work that has already been done in the area of study, thereby illuminating the current state of research on the topic. I undertook my initial extensive electronic search of databases in January 2013 and continued with the review of literature throughout the period of this study in databases which include JSTOR, MEDLINE, CINAHL and African e-Journals Project. My general internet search of literature also yielded useful writings, particularly those which related to the local context. In the search, I used the keywords: Zimbabwe, Africa, disability, sexuality, gender, culture, gender based violence and disabled women. I also hand searched for books in the libraries of the University of Cape Town and the University of Zimbabwe.

The discussion in this chapter illuminates the results of all my literature search strategies. Among other things, I pursue the key concepts of disability, sexuality, and gender, echoing an African background alongside which this study revolves, but taking care not to discard relevant debates or ideologies from other parts of the world. One need not be a disability practitioner, a sexologist or a feminist to realise that the literature reflects a serious paucity of writings pertaining to the specific area of study. In Zimbabwe, the scanty literature that is distinctive to disabled women thus far is drawn predominantly from media publications (Masakadza, 2012; Pasipanodya, 2013). Such a scarcity exposes the neglect of the topic in serious institutional and educational research and writings, an area of weakness which this study is attempting to rectify.

I start off by examining the dominant patterns of sexual practices in Zimbabwe including the hegemonic standpoints on sexual orientation which esteem heterosexuality whilst despising

and prohibiting different sexual orientations. The dearth of local literature on the sexuality of disabled women in particular, leaves me with no choice but to draw references from contextual literature which assumes that all women are non-disabled. I examine the notion of Gender Based Violence (GBV), on the grounds that it is closely intertwined with the experiences of sexuality of disabled women within a context of the women's lower status in a patriarchal society. I discuss the prevailing discourses of disability in Zimbabwe in order to give background to the way in which disability and treatment is conceptualised in the country and to ultimately examine the ways in which such an understanding influences the experiences of sexuality of disabled women. In the final section I examine the subject of the sexuality of disabled women from an international perspective on the grounds that whilst it is critical to develop indigenous philosophies of African sexualities, African scholars can still mirror upon Global Northern concepts or ideologies to allow a broader reflection on African sexualities (Tamale, 2011). Below, I discuss the practices of sexuality that are common in Zimbabwe, in order to place the subject of this study in its broader national context.

3.1 Practices of sexuality in the local context

I explore in this section the sexuality of Zimbabwean women in general, alongside a backdrop of a shared context that is rooted in hegemonic masculinities for both non-disabled and disabled women. That is not to deny the fact that the experiences of sexuality of disabled women often vary in a unique way that is linked to disability as revealed by US studies (Nosek, Foley, Hughes, & Howland, 2001; Saxton, Curry, Powers, Marley, Eckels, & Gross, 2001), but it is a strategy of coping with the contextual dearth of writings on the subject. In any case disabled women and non-disabled women may have certain common experiences of sexuality. Where possible, I draw on Zimbabwean media publications that are available and that cover the subject of disability and sexuality.

I remind the reader that the dominant practices of sexuality in Zimbabwe uphold heterosexuality and denounce different sexual orientations on the continuum of sexualities. Studies carried out in Zimbabwe by Epprecht (1998, 2013) reveal that whilst different sexual orientations are generally regarded as un-African, there is evidence of traces of homosexuality in pre-colonial Zimbabwe as depicted in oral tradition on ethnic healing and punishments and on a Bushman painting. Nevertheless, debates on alternate sexual orientations have become highly volatile in Zimbabwe, with supporters and critics hauling

insults at each other. In addition, the Government of Zimbabwe outlaws same sex marriages in the country's constitution (Government of Zimbabwe, 2013). It is therefore not surprising that the acquisition of a husband and having children within the parameters of a heterosexual marriage awards women respectability within families and communities (Zinanga, 1996). The discussion in the following section, encompasses the subjects of marriage and reproduction, "small houses" (mistresses) and marriage laws, as well as issues of reproduction and traditional practices of enhancing eroticism.

3.1.1 Marriage and reproduction

In this section I discuss dominant perspectives that surround the issues of marriage and reproduction in Zimbabwe. Similar to practice in India (Balodhi, 1992), studies carried out in Zimbabwe reveal that society frowns upon women who lose their virginity before marriage (Sherman & Bassett, 1999), alongside an argument that losing one's virginity before marriage brings shame to the bride and her family. Such traditional philosophies instigate the conviction that any woman who is not a virgin at the time of marriage, is morally suspect (Zinanga, 1996). The problem with such a tradition is that society applauds the virginity of women before marriage, whilst it maintains silence on the sexual relations of men before marriage, thereby using a double-standard model which seeks to safeguard the tenets of patriarchy. It is therefore not surprising that a virgin may be infected with the HIV virus immediately upon marrying a male partner who would have been seeking to ascertain his manhood in other places. Although attitudes towards virginity customs are beginning to change with "modernity", conservative Zimbabweans still uphold such beliefs as a prerequisite for marriage which begins with the payment of *roora* (bride price), as discussed below.

Once a woman is married, as symbolised by the traditional practice where a man pays *roora* (the bride price) for the woman, some men begin to demand sex from the wife whenever they want (Chabata, 2012). The masculine belief is that the traditional requirement of men to pay *roora*, upon marriage, symbolises the man's buying of conjugal rights. Chabata (2012) notes that the risk of contracting HIV is fuelled by such traditional arrangements because the payment of *roora* is used by husbands as a "passport" to control the sexuality of women and in some instances husbands demand unprotected sex. Studies carried out in Zimbabwe (Chabata, 2012) and South Africa (Selikow et al., 2002) reveal that such a situation depicts a

traditional practice where some men treat women as commodities that are bought and sold on the open market, to be used by men under a form of coercion that undermines the power of women to negotiate safe sex.

The above practices resemble a kind of GBV that is perpetrated by men against women in situations where, as noted in South African studies, masculine behaviours flow from cultural norms of gender identity to increase the vulnerability of African women to STIs and HIV/AIDS (Naidu & Ngqila, 2013; Jewkes & Morrell, 2010). In Zimbabwe, it is not uncommon for husbands to argue that: “*kana mombé dzangu dzandakaendesa kuvabereki vako seroora dzanga dzisina kupfeka kondomu ini ndinopfekerei kondomu?*” (If the cows that I sent to your parents as bride price were not wearing condoms, why should I wear condoms? (Chabata, 2012). As previously mentioned, the point is that the payment of *roora* gives the men a sense of entitlement and power to direct and control the experiences of sexuality of their wives. Nevertheless, Chabata states that whilst some women argue that the payment of *roora* fuels GBV within their marriages, others argue that it is a traditional practice which earns the women respectability among their kinship relations and in society at large.

The refusal of husbands to engage in protected sex as discussed above, also resonates with the findings of a study undertaken in South Africa which revealed that some men who do not use condoms during sex, are those who believe in the concept of “tata machance” (take a chance), which is derived from the slogan of the South African lottery (Selikow et al., 2002). Such a notion attributes death to fate and argues that people cannot defend themselves from death because death happens at pre-set times. A quote drawn from Selikow, Zulu, and Cedra (2002, p. 25) exemplifies such a belief: “AIDS or no AIDS you can’t run away from death. When it is time to die you die, you can’t run away.” Another South African study revealed that some women perceive their husbands who refuse to engage in protected sex as “good” for as long as they are not being physically violent towards them (Naidu & Ngqila, 2013). The shaping of any kind of masculinity is therefore inevitably structured by gender relations that are mutual and not entirely by the dominance of men; but that does not mean that women are totally free from oppression, which also manifests in reproductive issues, as discussed below.

In relation to reproductive issues and informed by the hetero-normative view of “life creation”, some African societies have been able to fashion a supremacy of heterosexual practice which is oriented towards reproduction (Makinwa-Adebusoye & Tiemoko, 2007). The only justification for sexual feelings and expression is therefore narrowed down to penetration in sexual intercourse and the resultant reproduction. A study carried out by Epprecht (1998) in Zimbabwe, revealed that the evidence of fertility has historically been regarded as a significant element in an appropriate marriage and in the social meaning of both masculine and feminine maturity. It is therefore not surprising that most Zimbabweans find it difficult to understand the existence of different sexual orientations other than heterosexuality, in a context where families use coercive power to impose compliance with heterosexual norms (Epprecht 1998). Epprecht states that Zimbabweans are so fearful of different sexual orientations, including homosexuality, to the extent that they would rather maintain silence on the subject. One is therefore left to wonder about the location of a disabled woman of a different sexual orientation other than heterosexuality in a context where, as will be discussed in section 3.3, most Zimbabweans are also generally afraid of impairment.

The reproduction-oriented heterosexual practices that are dominant in most African communities are closely intertwined with the male child preference syndrome. Studies carried out in Zimbabwe (Choruma, 2007) and Nigeria (Adeyele & Okonkwo, 2010) reveal that male children are generally more preferred than girls. The perception is that boys preserve the family name, whereas girls are raised to become a husband’s property and to inherit a husband’s surname upon marriage. A woman who fails to bear children at all is likely to suffer from depression; infertility induced depression among women in Zimbabwe is supported by evidence from a study carried out by Abas and Broadhead (1997) in township urban settings in Harare, Zimbabwe. The study indicated that women living in Harare experience a high prevalence of depression on a yearly basis, for reasons that include infertility, marital or other relationship predicaments. The woman bears the blame for most issues that go wrong within a heterosexual marriage even in cases where she may not be at fault and yet as previously noted, the woman may still esteem heterosexual marriage, as discussed below.

As previously mentioned, in Zimbabwe, the practice of acquiring husbands, settling down in marriage, having children and exploring one’s feminine sexuality within the parameters of

the marriage is a traditionally respectable achievement (Zinanga, 1996). Consequently, women tend to “worship” their husbands alongside a backdrop of a feminine sexuality that is defined by the extent to which a woman is able to please her husband sexually. However, the national 2011 statistics on HIV/AIDS reported that compared to other demographic groupings, married women had the highest rate of HIV infection (National Aids Council of Zimbabwe, 2012). Such statistics are not surprising, given that some women may engage in unsafe sexual practices in a desperate bid to sustain their marriages in a context where the threat of a *small house* (mistress), which I discuss below, is perpetually looming.

3.1.2 The practice of “small houses” (mistresses) and marriage laws

In this study I draw the meaning of a “small house” from local HIV prevention experts who state that a “small house” is: “...an informal, longterm, secret sexual relationship with another woman who is not a man’s legal wife, carried on in a house that is a smaller version of the man’s own home in another residential suburb (Chingandu, 2005, p. 1) The same author postulates that the “small house” concept is not limited to Zimbabwe only, but it stretches beyond the borders of the country into other southern African nations, where it is labelled differently. However, the results of focus group discussions that were held by Chingandu (2005) with men and women in Harare, Zimbabwe, revealed that a husband, who becomes uninterested in his wife, often acquires a “small house” or “small houses” to compensate for his wife’s alleged weaknesses. The wife may be criticised for losing sexual attractiveness, infertility, aging, being boring, not cooking properly (Chambati, 2012) or giving birth to a disabled child. The “small house” is usually a younger woman, who in most cases may be half the age of the husband but who may even be prepared to have children with the married man in exchange for material provisions (Chingandu, 2005). However, in most cases “small houses” are not meant to replace the first wife, but they are meant to run parallel to the man’s marriage.

“Small house” relationships are usually done in secret but if the first wife finds out and if she does not opt out of the marriage, she remains married on paper (marriage certificate), and enjoys the privilege of being the wife and keeping her husband’s surname within a patriarchal society which looks down upon unmarried women (Chingandu, 2005; Mapimhidze, 2012). The Biblical concept of submission to husbands as articulated in Colossians 3 vs 1, contributes to the submissiveness of women to men in marriage (Biblica, Inc, 2011), even in

the face of “small houses”. Some men justify the “small house” practice by referring to an unwritten clause of African tradition: “it’s our African culture to have more than one woman” (Chambati, 2012), after all, monogamy is for White people. However, research by HIV prevention experts has indicated that the “small house” practice in Zimbabwe is a main driver of the HIV pandemic (Chingandu, 2005). I notice that local literature assumes that all “small houses” are non-disabled women; hence the literature is silent on “small house” practices of disabled women or that of disabled women’s husbands.

Marital laws which are meant to curb the practice of “small houses” appear to be contradictory. As such, the Marriage Act (Government of Zimbabwe, 1964) has been criticised by local legal experts as being defective, because it appears to recognise only one man one wife civil marriages, when the reality on the ground is different (Gonda, 2013). Furthermore, men who marry under Chapter 5:11 are not allowed to marry more than one wife or to have a “small house”, but polygamous unions are allowed under Chapter 5:07 which permits one man to marry as many wives as he chooses and each wife can have her own marriage certificate. In addition, the customary marriage also allows a man to marry as many wives as he wants by paying *roora* (bride price) for the women, but if the marriages are not registered the women will not receive marriage certificates. The man has the final decision-making power in the household and he controls all types of property, including his wife or wives, who are also regarded as his possession (Riphenburg, 1997). In a few instances, a man may pay *roora* (bride price) for a “small house”, particularly in cases where the man would have fathered children with the “small house”. However, children that are born with “small houses” may not use their father’s surname, as part of a strategy which seeks to “conceal” the adulterous relationship, in case a woman who is married under Chapter 5:11 decides to legally sue the “small house” for engaging in an adulterous relationship with her husband. Nevertheless, women try to prevent their husbands from acquiring “small houses” through traditional practices of enhancing eroticism, as discussed below.

3.1.3 Traditional practices of enhancing eroticism

Very little research has been undertaken in the area of traditional practices of sexuality that African women engage in, with the objective of enhancing eroticism. One practice that has been widely described amongst women in African countries such as Uganda and Zimbabwe is the stretching of the labia, a practice which represents a woman’s initiation into sexuality

(Bagnol & Mariano, 2008a, 2008b; Tamale 2005; Williams, 1969). In a study carried out among Shona women in Zimbabwe it was noted during medical observations that most of the women possessed elongated labia (Williams, 1969). Statistics drawn from the study revealed that 94.4% of the Shona women who participated in the study, which included measurement of the labia during regular antenatal procedures, showed such elongation.

In the study mentioned above, Williams (1969) slightly stretched and measured the left labia minora from the midline of the clitoris outward and found varying lengths which ranged between 1.0cm to 8.0cm, and an average of 3.9cm. A study carried out in Mozambique, revealed that the appropriate size of the vaginal lips drains the wetness of a vagina thereby accomplishing its required dryness (Bagnol & Mariano, 2008a, 2008b). Although there is very little research that has been done on the subject of elongating labia in Zimbabwe, the available scanty literature on the topic (Williams, 1969) is devoid of disabled women, thereby implying that women who engage in such traditional practices of sexuality are all non-disabled. Apart from elongating their labia, local women also use vaginal products to enhance the functioning of the vagina in coitus.

The use of traditional vaginal products among African women represents a measure of modifying genital organs to enhance sexual pleasure (Bagnol & Mariano, 2008a, 2008b; Tamale, 2005). The practice is common in Zimbabwe, and it is also found in Cameroon, Mozambique, South Africa, Uganda and Malawi (Bagnol & Mariano, 2008a, 2008b). A study carried out in Mozambique revealed that both men and women believe that the process of giving birth to a baby as well as continuous penetrative sex widens the vaginal canal, rendering the experience of sexual penetration unpleasant, particularly for the man (Bagnol & Mariano, 2008a, 2008b). As such, women take the initiative to use various products to tighten the vagina to make sex more pleasurable under conditions of dry sex in a heterosexual union. As noted by Bagnol and Mariano (2008a), the insertion of vaginal products is meant to tame the sexual partner and to keep him from engaging in sexual relations with other women; hence it is metaphorically referred to as: *holding onto one's partner*.

The women's perception is that men generally favour dry sex, hence highly lubricated women run the risk of being accused of having had sexual intercourse with other men previously, or of not having prepared appropriately for sex (Bagnol & Mariano, 2008b). In addition, the women in Mozambique revealed that men often liken a sexual experience with a

wet woman to “...having sex in a glass of water’, referring to the absence of pleasure and to the noise which results” (Bagnol & Mariano, 2008a, p. 579, 2008b). The use of vaginal products discourages the use of condoms, given that protected sex would defeat the purpose of using the products which are meant to increase pleasure through conventional contact of the vagina and penis in coitus (Bagnol & Mariano, 2008a). In Mozambique, health staff indicated possible negative health outcomes of insertion and use of vaginal products: inflammation and swelling of the vagina, uterus cancer, infections and increased exposure to STIs and HIV/AIDs infections due to lacerations on both the vagina and penis due to dry sex (Bagnol & Mariano, 2008a, 2008b). However, very little research, if any, has been undertaken from a public health perspective to examine the link between the traditional sexual practices and vulnerability to HIV infection, thereby making it difficult to draw conclusions on the subject. However, in the following section, I discuss the link between sexuality and GBV.

3.2 Sexuality and gender based violence (GBV)

In this section, I examine the concept of GBV in an effort to analyse its link with the sexuality of disabled women within a framework of the lower status of the women in patriarchal contexts. There is not a single definition of GBV which applies in all societies of the world, hence the concept is defined and conceptualised differently in various settings (Ellsberg & Heise, 2005). Terms such as, for example, “domestic violence”, “intimate partner violence”, “spousal abuse”, “battered women”, “sexual abuse” and “violence against women” are often used differently or interchangeably in various settings. In this study I adopt the definition that has been advanced by the UN Beijing Declaration and Platform for Action (United Nations, 1995, D.113), hence I consider GBV or violence against women as: “...any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.”

By adopting the above definition of GBV I do not mean to ignore the assertion made by Ellsberg and Heise (2005) which states that women can be both perpetrators and victims of GBV, but I mean to say that such violence, particularly within families, is commonly perpetrated by men against women. In spite of the “vagueness” that surrounds the concept of GBV, the emergence of the above definition represents an international agreement on the

manner in which GBV dynamics should be conceptualised (Russo & Pirlott, 2006). Furthermore, a WHO/PATH study carried out by Ellsberg and Heise (2005, p. 11) noted an increased global agreement on the notion "...that the abuse of women and girls, regardless of where it occurs, should be considered as 'gender-based violence,' as it largely stems from women's subordinate status in society with regard to men...". GBV is therefore, a multifaceted notion which is experienced in different ways as entrenched in patriarchal and cultural structures of society.

Embedded in GBV are practices of sexual coercion which represent a form of gendered power relations which are common in heterosexual relationships (Jewkes & Morrell, 2010). Although men are also vulnerable to sexual coercion, most victims are women and girls, who experience a myriad of acts such as indecent assault, rape, forced marriage, being involuntarily impregnated and sexual injuries (Amnesty International and CODESRIA, 2000). Whilst sexual coercion is often associated with aggressive sexual behaviours, it may also take the form of emotional pressure such as making the victim feel obliged to take part in sexual deeds against her will (Ellsberg and Heise, 2005). The same authors state that the hallmark of coercion is that women do not usually have the leverage to make sexual choices, and any attempt to make such choices is often accompanied with grave consequences of either an economic, physical or social nature.

A study carried out in South Africa revealed that some men tell young women that there is no point in having a love relationship if people cannot have penetrative sex and that people who are "in love" should be able to have sex as much as possible (Wood & Jewkes, 1997). Agreeing to engage in a love relationship therefore symbolises an acceptance to have penetrative sex and to be available sexually. The same study revealed that young women who refuse to have coitus with their partners are usually beaten up for such denials and they also get beaten if they are seen by their male partners talking to other men. As previously noted, such a form of sexual behaviour may be attributed to a kind of gendered power relations which is prevalent in heterosexual relationships (Kalichman, Williams, Cherry, Belcher, & Nachimson, 1998; Russo & Pirlott, 2006; Wood & Jewkes, 1997), as further highlighted below.

A US publication which describes "recent" research results of the link between gender, power, culture, sexuality, intimate violence and the negative outcomes of GBV, among other

things, produces evidence of the desire of men to control women on the grounds that men perceive themselves as more powerful than their female partners (Russo & Pirlott, 2006). Dutton, cited in Russo and Pirlott (2006), states that in cases where men feel that they are not asserting such power and control, they may perpetrate GBV against their feminine partners as a means of safeguarding such traditional ideologies. In Zimbabwe, statistics reveal that about 99% of domestic violence offenders are men, whilst 95% of the victims are women and girls (UNFPA Zimbabwe, 2011). Of notable concern is that such statistics do not provide a distinct overview of the domestic violence perpetrated against disabled women in Zimbabwe. However, it is undisputable that the unequal gender relations that sustain the legitimacy of such masculine violence tend to buttress a patriarchal view of the world in which feminine subordination becomes a norm, in spite of international and local laws that direct gender equity.

Despite international and local legal instruments prohibiting violence against women, various cultures around the world, including African culture, allow husbands to beat up their wives as a form of discipline or a way of resolving family conflicts (Kimani, 2007). Kimani states that masses of African and Asian women endure beatings or other kinds of viciousness from their husbands or close companions. A study carried out in South Africa revealed that whilst it is not expected that men should harm women, the use of modest violence to assert men's control of women is traditionally acceptable (Jewkes & Morrell, 2010). In Zimbabwe, wife beating may be interpreted to mean the expression of love by a husband as well as a tool for stabilising the marriage, hence the first beating is expected to occur immediately after the wedding (Chirume cited in Taylor & Stewart, 1991). It is therefore culturally acceptable for a husband to discipline his wife through modest beatings, albeit without using unsafe weapons such as knives or axes that are harmful. However, a WHO/PATH study carried out by Ellsberg and Heise (2005) reveals that injury is not the only primary health outcome of violence against women, but health consequences may include among others, psychosocial disorders, depression and anxiety.

In Zimbabwe a lot has been accomplished in relation to the promotion of women's empowerment and gender equality (UNFPA Zimbabwe, 2011). Such achievements are represented by the fact that the country has signed a variety of regional and international conventions, protocols, declarations and treaties that are aimed at promoting and creating a conducive setting for the achievement of women's empowerment and gender equality.

However, whilst UNFPA acknowledges Zimbabwe's compact legislation programme, UNFPA has noted that the status of women from a political and socio-economic perspective remains quite low (UNFPA Zimbabwe, 2011). Furthermore, the majority of women lack awareness of the rights that are extended to them by the law, and due to economic hardships they may not be able to instigate and pursue legal processes. In addition, the women may also be fearful of violating traditional laws and infringing upon their cherished relationships with kinfolks. Whilst UNFPA Zimbabwe (2011) has illuminated the prevalence of GBV that is perpetrated against women in Zimbabwe, it has remained silent on such violence in so far as it is distinctly experienced by disabled women.

In their publication of an analysis of "current" and relevant peer-reviewed studies in the US, Plummer and Findley (2012) stated that whilst the visibility of literature on GBV against girls and women worldwide is unquestionable, very little research has been undertaken on GBV that targets disabled women in particular. Such a scenario illuminates society's reluctance to recognise the reality that GBV against disabled women could be happening. However, research has indicated that disabled women may experience GBV in the same manner, if not more than their non-disabled counterparts (Ferres, Megías, & Expósito, 2013; Nosek et al., 2001; Plummer & Findley, 2012). There is therefore evidence that disability introduces an additional layer of vulnerability to GBV in the lives of women. As such, Ferres, Megias, and Exposito (2013) highlight the fact that people with impairments, and particularly physical impairments, are usually targeted for violence. As noted in Chapter 2, the perspectives of the normate generally consider the bodies of disabled people to have departed from the norm; it therefore follows that disabled women may be viewed as easy targets.

Some perpetrators of sexual abuse may perceive the notion of being in an intimate partner relationship with a disabled woman as a chance to exploit her (Plummer & Findley, 2011). Those with psychosocial impairments may be unable to realise that they are being abused; hence they may not see the need for them to seek assistance (Nosek et al., 2001). In addition, disabled women who experience a delayed start to their sexual experience are likely to believe that they do not have much of a choice but to accept abusive relationships. However, some scholars (Nosek et al., 2001) have called for the development of interventions that enable disabled women to among other things recognize abuse and to extricate themselves from abusive locations. However, such a response could be challenging considering that

among other things the experiences of GBV within African contexts are generally surrounded with silences, as discussed in the following section.

3.2.1 Silences surrounding issues of GBV

The silence that surrounds issues of sexuality in most African communities (Interesting Interests, 2009; Reid & Walker, 2005; Tamale 2011), may delay the process of revealing incidences of sexual violence. Such issues do not often come to light immediately after the event and it may take several years for experiences of abuse to be revealed (Amnesty International 2004). In addition, women may be hesitant to publicise their experiences of sexual abuse, due to the stigma and discrimination associated with the experience as well as death threats from either the perpetrator or community. In cases where trials are instigated, such trials may result in unfairness to women, as women may delay disclosure and the seeking of justice. In addition, the Amnesty International Report (2004, p. 18), highlights the fact that “Indifferent or ineffective justice systems, repressive governments and the lack of a public demand for accountability may also cause many years to lapse before women demand redress.” It therefore follows that perpetrators may fail to be exposed or prosecuted, thereby paving the way for the offenders to perpetuate further abuse. However, the conceptualisation of sexual abuse may differ in accordance with the socio-economic class of the victim, as discussed below.

Based on their US study, Plummer and Findley (2012) state that disability may cause a person to be at an increased risk of sexual abuse in cases where they depend financially, emotionally or physically on the perpetrator. To mitigate such vulnerability, pronouncements on human rights pertaining to sexuality and disability award individuals the mandate to seek redress in the event of sexual abuse. However, from an African perspective and as the results of ethnographic studies that were undertaken in southeast Nigeria reveal, whilst existing human rights instruments are crafted along the lines that the body belongs to an individual, such instruments may not be applicable in some African contexts (Izugbara & Undie, 2008). That is so, because within some African settings, bodies do not belong to the individual but they belong to the entire family and community, influenced at most by cultural ideologies. As such, in most African communities a person does not own his or her body; hence people usually seek to claim their rights within a shared space, as exemplified below.

The Ngwa-Igbo people of Nigeria present a vivid example of the way in which community notions of body ownership are enacted in everyday life (Izugbara & Undie, 2008). For example, the same authors state that although rape is widely recognised as a criminal offence amongst the Ngwa-Igbo people of Nigeria, the transgression is regarded as having been committed by one community against another and not by one individual against another (Izugbara & Undie, 2008). Consequently, it is the community that decides on the form of punishment or payment of damages that should be levelled against the perpetrator. In addition, a communal ritual of cleansing both the rapist and the victim is conducted, after which both parties are put back into their particular communities. In such cases, the community becomes the route through which an individual can realise their rights; hence legal instruments that portray the body as being owned by the individual may run the risk of being resisted, particularly in contexts that are framed by colonial perspectives, as discussed below.

A South African study revealed a colonial gender order that was characterised largely by racial discrimination (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). As a result, a lot of Black men were offered employment in unskilled jobs that were not well paying, and some could only get seasonal employment, or be unemployed. Such a scenario served to deny Black men the opportunity to assert their masculinity through material or professional success, thereby igniting them to seek to affirm their manhood in homosocial or criminal settings in their relationships with Black females (Jewkes & Morrell, 2010). The situation has been blamed for shaping an African femininity of silence, passivity and obedience, across various areas which include sexuality, given that the Black African woman would in most cases be lacking economic independence and would be dependent on the Black African man. Nevertheless, the situation is different in cases where various forms of disability present an additional layer of oppression to disabled women, as discussed below.

Literature reveals that the nature of impairment makes a difference in relation to rape experiences, given that circumstances appear to be worse for Deaf women, who are unable to scream for help (Hanass-Hancock, 2009b). In addition, Deaf people experience communication problems if they try to report the rape to the police, because in most cases the police are unable to speak sign language. In relation to marriage, most Deaf females marry Deaf males, and both partners are usually ill-prepared to take up adult responsibilities and roles (Jacobs cited in Beker & Jauregui, 1985), perhaps due to a lack of sex education. The

situation calls for further research which brings to the fore the complexities of GBV that is leveled against Deaf women in the Global South, and in particular in African contexts. Literature also reveals that the experiences of GBV are also distinctly different for women with intellectual impairment, as discussed below.

A British study revealed that it is difficult to obtain information on the kind of abuse that could have been experienced by women with intellectual impairment (McCarthy & Thompson, 1997). That is so because victims may not be able to distinctly narrate what transpired, particularly in cases where the incident would have taken place in the distant past compared to recent times. However, McCarthy and Thompson (1997) note that, in some cases, stories of sexual abuse are shared by the victims without them even realizing that what they have experienced is sexual abuse. Whichever way, it is critical for researchers to record all forms of abuse as experienced by women with intellectual impairment and to give the women the vocabulary to describe the abuse, if such women are ever to receive effective and appropriate support. Linked to the issue of silences surrounding issues of GBV which I have discussed in this section is rape, which takes place both in and outside of the “sacred” institution of heterosexual marriage, as discussed below.

3.2.2 Rape in and outside marriage

In Zimbabwe, if a woman is raped by a man outside of marriage, blame is usually pointed at the woman rather than on the male perpetrator (Zinanga, 1996). The same author states that the first question that is often asked is: *“anga akambopfekeiko”* (what was she wearing?). Yet, the World Health Organisation (1997) warns against insensitive or victim blaming attitudes on the grounds that such attitudes award invalid excuses to perpetrators, bolster self-blame and seclusion, undermine the self-confidence of women and reduce the chances of them making an effort to seek help. In Zimbabwe, short skirts and trousers are generally not accepted as decent feminine dress; hence they are often regarded as the preserve of wayward women (Zinanga, 1996) or prostitutes. Although attitudes are beginning to change with ‘modernity’, minimum skirt length is traditionally expected to be below the knees, and chemises are expected to leave no part of the cleavage showing. Furthermore, in the event that a woman is raped while wearing a short skirt or tight trousers, she is accused of having invited trouble upon herself by being improperly dressed, revealing her body parts and arousing the sexual feelings of men.

Some publications from the Global North (Heise, Ellsberg, & Gottmoeller, 2002) have indicated that marital rape is considered to be a form of GBV at international level. However, Zinanga (1996) states that most Zimbabweans do not believe that there is such a thing called marital rape, because the “job description” of a married woman is to be sexually intimate with her husband whenever he desires, even in cases when the sex endangers the woman’s life. The same author states that in Zimbabwe, the notion of conjugal rights is interpreted to mean that such rights are the rights of men and not of women. Failure to bow down to such patriarchal demands may result in the wife being castigated for denying the husband such critical matrimonial rights, to the extent that she may even be dragged to civil court to answer such charges. As a result, women who experience marital rape often suffer in silence believing that it is the right of men to dominate and regulate feminine sexuality. The African traditional practices that regard issues surrounding sexuality as sacred matters which are not meant for public discussion (Reid & Walker, 2005), make matters worse, as women suffer in silence. I discuss the subject of transactional sexual arrangements below.

3.2.3 Transactional sex

Although the UNFPA Zimbabwe (2011) is silent on the distinct experiences of sexuality of disabled women in Zimbabwe, it states that the low economic status of women in the country exposes them to risky sexual behaviours, thereby increasing their vulnerability to GBV and HIV infection. However, statistics drawn from 15 developing countries including Zimbabwe reveal that disabled people are poorer than their non-disabled counterparts and therefore more vulnerable to practices of transactional sex (Mitra, Posarac, & Vick, 2013). There is a growing body of work on transactional sex in South Africa such as Hunter’s work under which the researcher was examining the materiality of everyday sex (Hunter, 2002). He states that transactional sex encompasses the giving of gifts in exchange for sex.

Transactional sex can be likened to prostitution in relation to it being sex which takes place outside of marriage with multiple partners and which involves the payment of cash or gifts (Hunter, 2002). However, Hunter argues that transactional sex differs from prostitution in the sense that participants are often referred to as “boyfriends” and “girlfriends” and not as “clients” or “prostitutes”. According to a study undertaken by Leclerc-Madlala (2003) in a Durban township in South Africa, the Global Northern delineation of prostitution has often been applied in African contexts to describe various sexual exchange relationships.

Nevertheless, by the end of the 1990s, African social scientists had begun to use the words “informal sex” or “survival sex”, to denote exchange relations that take place in Africa, thereby seeking to give a more precise, Afrocentric and sensitive definition which is relevant to the continent, in a context where transactional sex is conceptualised in different forms, as further discussed below.

Studies carried out in South Africa indicate that in some instances transactional sex is regarded as normative, hence it often becomes a key driver of multiple, non-condom use and non-marital sexual relations, which ultimately fuel the spread of HIV (Hunter, 2002; Leclerc-Madlala, 2003). However, perceiving women as passive victims of transactional relationships is erroneous, because women often approach the negotiating table of such relations with tact, in ways that may either challenge or reinforce patriarchy. Women who participated in a South African study argued that men exploited them in the same way that the women exploited the males in what is called a two-way or give-and-take situation (Leclerc-Madlala, 2003). In addition, people do not always engage in sexual exchange practices out of a need to survive, but some people who are able to meet their basic needs may do so for commercial purposes where they seek to acquire a higher class lifestyle in exchange for sex, by earning luxury items such as cell-phones, perfumes or nice clothes.

I discuss the prevailing contextual discourses on disability below, so that I may later examine the link between such discourses and GBV within a framework of the experiences of sexuality of disabled women in Zimbabwe.

3.3 Prevailing discourses on disability

Very little has been written about the cultural discourses on disability that prevail in Zimbabwe and in other African countries. However, in this section, I illuminate the manner in which disability is traditionally constructed within the context of this study with the aim of ultimately analysing the link between such ideologies and the sexuality of disabled women in Zimbabwe. Similar to other colonised African countries, Zimbabwe takes a twofold approach which defines disability in both modern and traditional terms (Mpofu & Harley, 2002). From a traditional perspective, it is believed that physical manifestations of disease or disability are not purely biological, but are symptoms of religious and cultural problems that elusively operate in a person’s life (Burck, 1989). The social and cultural setting of an ill or disabled

person and his or her family are considered to be part of each human body and the functions of such a body are influenced by a number of supernatural spirits (Burck, 1989; Kabzems & Chimedza, 2002; Mpofu & Harley, 2002). The belief is that such spirits, the breaking of taboos and witchcraft are some of the major causes of a person's impairment, as discussed below.

3.3.1 The breaking of traditional taboos, supernatural spirits and witchcraft

Within most African contexts, including in Zimbabwe, impairment in children often signals parental violation of taboos, which are predominantly related to sexuality and include a failure to have lots of sex in the earlier months of a pregnancy, or having sex outside of marriage, and incest (Dengu cited in Burck, 1989). Burck states that in pre-colonial Zimbabwe, disabled children were dealt with in three ways: they would be killed, be assigned to a traditional healer for treatment, or be hidden somewhere within the family sphere. In Tanzania people who have albinism continue to be mutilated or killed for ritual purposes (Masanja, 2015). However, whilst the practice of hiding away disabled children due to shame may still be prevalent, the practice of killing disabled children in Zimbabwe has now been discontinued. Nevertheless, such attitudes serve as a barometer that can be used to measure the extent to which people in Africa, including in Zimbabwe, are fearful of disability. Below, I discuss the influence of super-natural spirits as one of the perceived major causes of disability in Zimbabwe.

As previously indicated, in Zimbabwe impairment is traditionally believed to be caused by supernatural spirits, which come in various forms. *Mamhepo* (a malevolent spirit or the winds) is the kind that can easily be thrown at another person by people who are jealous of that person's success or who for one reason or another harbour bitterness, anger or hatred towards that person (Mpofu & Harley, 2002). Such spirits are understood to be the ones that can cause another person to be injured resulting in illness which ultimately leads to impairment. Traditionalist Zimbabweans also believe in the spirit of *ngozi* (avenging spirit), which is a spirit of a dead person whose death is alleged to have been instigated by another person (Chavhunduka, 1998; Mpofu & Harley, 2002). The belief is that the avenging spirit rises from the grave of the deceased to torment the life of the person who secretly plotted the death, to bring illness, death or disability upon him or members of his family.

The *mudzimu* (benevolent spirit) is usually the spirit of a dead elderly member of the family such as a father or mother, grandfather or grandmother (Mpofu & Harley, 2002). Such a spirit is regarded as the first point of connection in a very long string of ancestors who mediate with God for the protection of all surviving members of the deceased's family descent. The spirit is responsible for taking care of all surviving family members of the deceased by protecting them from all forms of vulnerability (Chavhunduka, 1998; Mpofu & Harley, 2002). However, when the spirit is offended or disrespected it may retaliate by taking away its shield of protection, resulting in an errant family being exposed to all kinds of vulnerabilities, which may include illness, injury, disability or death.

Witchcraft is also widely believed to be another major cause of impairment in Zimbabwe (Burck, 1989). Witches are deemed to have the power to eat dead bodies, dance at night in the fields while stark-naked as well as to inflict illness, death or other adversities to those who dare cross their paths (Chavhunduka, 1982), and such "adversities" may include impairment. The colonial era definition of witchcraft as articulated in the Witchcraft Suppression Act (1899: Chapter 73, 2), delineates witchcraft as, "...the 'throwing of bones', the use of charms and any other means or devices adopted in the practice of sorcery." However, such a definition has been criticised for failing to give a true reflection of the meaning of witchcraft in Zimbabwe (Chavhunduka, 1982). Chavhunduka states that the automatic aligning of all charms with witchcraft is wrong, because charms may be used for other purposes such as to immunise people against certain diseases, to gain bodily strength or to erotically attract people of the opposite sex. Such a skewed delineation of witchcraft falls into the category of what Rutherford (1999) describes as attempts by Westerners to understand indigenous people by using Western rationales. Closely linked to the traditional conceptualisation of disability which I have discussed in this section is the resultant threefold approach to healthcare, which I discuss below.

3.3.2 Traditional, religious and contemporary healthcare approaches

Driven by an immense fear of disability which arises from the prevailing cultural discourses on disability, most African communities including those in Zimbabwe (Muderedzi & Ingstad, 2011) and Zaire (Devlieger, 1995), consider it important to establish the reasons why impairment has come upon them or members of their family first, before seeking treatment or rehabilitation. In Zimbabwe, the "voyage" often begins with the consultation of a traditional

healer, who is believed to possess the power to explicate causes of the impairment to the consulting family members (Muderedzi & Ingstad, 2011). Traditional healers do not provide explanations of the causes of impairment in relation to a person's body only, but the healer's enlightenments also encompass a person's entire social background. Consequently, the process of choosing a mode of treatment can only begin after the traditional healer has illuminated the cause of the impairment.

The contemporary healthcare system may progressively take over the upkeep of a disabled person, but only after the traditional healer has addressed the question of why impairment has come upon that individual (Burck, 1989). Examining the issue of disability and social suffering in Zimbabwe, Muderedzi and Ingstad (2011) state that when faced with impairment, the "why?" question usually takes centre stage in most families, ahead of treatment or rehabilitation. Compared to Western trained doctors who just rush to write medical prescriptions, traditional healers take their time to expound on the causes of impairment, taking the family, community and ancestral spirits of the person into consideration (Mpofu & Harley, 2002). However, Devlieger (1995) states that the "why" question is undervalued in Western society where disability is generally looked at from an angle of coincidence as further discussed below.

Deliberating on the perception of impairment as coincidence, Devlieger (1995, p. 98) quotes Robert Murphy's Western oriented viewpoint and states that such a perspective could be common among disabled people in the West: "In all these years since the onset of my illness, I have never consciously asked, 'Why me?'. I feel that this is a very foolish question that assumes some cosmic sense of purpose and direction in the universe that simply does not exist." Murphy's utterances are intolerable in African contexts, including in Zimbabwe where the "Why me?" question is instigated by a practice of conceptualising impairment in a manner that views it as being deeply rooted in people's relations with their physical locations, ancestors, families, bride price, taboos and witchcraft (Burck, 1989; Devlieger, 1995; Mpofu & Harley, 2002; Muderedzi & Ingstad, 2011).

Among the Songye people of Zaire, the onset of impairment triggers an examination of relations between the impaired person and his or her environment, family, ancestors and bride wealth (Devlieger, 1995). However, if by the end of the day all these relations are perceived to be normal, then the cause of any form of impairment is apportioned to *Mwari* (God). Since

God denotes a realm that lies beyond the reach, influence or control of humanity, “God is a residual category that is used when no other cause can be found.” (Burck, 1989; Devlieger, 1995, p. 98). The common belief among people of Zimbabwe is that God has the power to punish people who engage in unethical behaviour such as incest by sending them disease (Chavhunduka, 1998) or impairment. As such when faced with problems, people often seek the intervention of God through prayers, albeit without completely “resigning” from occasional consultations of traditional healers with the hope that the ancestors may reveal an effective treatment method that may cure the impairment.

Traditional healers provide treatment and rehabilitation services from their homes which are located within the communities where disabled people live, and they cater for more than 80% to 90% of the people of Zimbabwe (Mpofu & Harley, 2002). It is believed that there are about 4 500 traditional healers, compared to approximately 1 400 Western trained doctors in Zimbabwe (Dandurad & White, n.d.). Nevertheless, the choice of a healthcare approach at the onset of impairment is largely influenced by the circumstances and initial diagnosis of the impairment by family members (Burck, 1989). Considering that an individual’s impairment is commonly regarded as a family affair, decisions pertaining to treatment and rehabilitation are usually taken at family level, in a context where contemporary healthcare approaches may also be considered, along a framework which is discussed below.

In Zimbabwe, contemporary rehabilitation services are predominantly located in major urban hospitals and other healthcare institutions, and such services are commonly offered by physiotherapists, nurses, psychologists or therapeutical technicians among other professionals (Burck, 1989). Furthermore, there is at least one functional hospital in every district, which is owned by either the government or missionary organisations. Such hospitals are headed by a general practitioner who runs the institution with the assistance of nurses and healthcare assistants. Burck states that rehabilitation services are usually inaccessible to the general public, particularly for those of low financial means (Burck, 1989). Healthcare and public transport affordability challenges (Dansereau, Zamponi, & Melber, 2005), exacerbated by the economic decline in the country as reported by Africaw (2015), may leave some people with no choice but to restrict their search of a cure for impairment from traditional healers.

Unlike the contemporary healthcare centres, traditional healers charge a negotiable fee for their services (Mpofu & Harley, 2002). In cases where full payment is not available at the

time of consultation, such fees can be paid in instalments of cash, or payments can be made in other forms such as cows, goats and harvested crops (Chavhunduka, 1998). However, other people may consult traditional healers on the grounds of a pure allegiance to culture or their social group's initial diagnosis of the cause of the impairment (Burck, 1989; Chavhunduka, 1998). It therefore follows that the consultation of traditional healers is not just the preserve of uneducated or poor people as some people may think, but it is a practice that is driven by traditional beliefs.

Considering the above circumstances, it is not surprising that compared to the consultation of modern healthcare practices, between 80% - 90% of the Zimbabwean population consults traditional healers (Dandurad & White, n.d.; Mpofu & Harley, 2002). Whilst contemporary healthcare systems are generally accepted throughout Africa, they have not substituted, but they have instead enlarged the healthcare system (Madamombe, 2006). It therefore follows that people are at liberty to select a healthcare mode which suits their beliefs and circumstances. However, considering that the conceptualisation of disability, sexuality and healthcare approaches may differ in accordance with context, I discuss the international perspectives of such aspects in relation to the sexuality of disabled women, below.

3.4 The sexuality of disabled women: An international perspective

There is a paucity of international research on the experiences of sexuality of disabled women. Such a scarcity has been attributed to the fact that disabled women worldwide are generally invisible in communities as well as the fact that both international and local researchers have shown no interest in pursuing the subject (Abu-Habib, 1997). However, without trying to be epistemologically dependent or lazy (Bakare-Yusuf, 2003), in this section I draw literature from the Global North, in an effort to mitigate the dearth of studies on the broad experiences of sexuality of disabled women in Africa, including in Zimbabwe. I justify such an approach by borrowing from the assertion made by Tamale (2011) that there are underlying similarities between the structures of the Global North and African societies, which should make us see the drawbacks of completely discarding philosophies from the Global North.

Although this study is aimed at developing indigenous philosophies of disabled women's sexualities in Zimbabwe, I concur with Tamale (2011) that African scholars can still reflect

upon Global Northern concepts to allow a broader reflection on African sexualities. In any case, even though Africa on its own is endowed with distinctive cultural practices of sexuality, some of its customs may be similar to those of indigenous people of countries in the Global North (Staples, 2006). An attitude of branding some concepts as being completely Northern and throwing them away on the grounds that they are irrelevant to the African context may therefore not yield much (Bakare-Yusuf, 2003). In any case:

...Africa has been part of Europe as Europe has been part of Africa and out of this relation, a whole series of borrowed traditions from both sides have been and continue to be brewed and fermented. To deny this inter-cultural exchange and reject all theoretical imports from Europe is to violate the order of knowledge and simultaneously disregard the contribution of various Africans to European cultural and intellectual history and vice-versa. (Bakare-Yusuf, 2003, p. 11)

A study carried out in Canada notes the dearth of literature about sexuality and disability in medical literature and medical school curricula (Basson, 1998). Such paucity has been attributed to various myths that surround the subject of disability and sexuality, which ultimately lead to the neglect of the sexual well-being of disabled women. Neglecting the sexuality of disabled women has resulted in society manufacturing and normalising various myths, such as, "...disabled women are asexual...disabled women who are single are celibate...disabled women cannot be mothers...disabled women should be grateful for sexual relationships..." (Basson, 1998, p. 359). All these myths add up to trigger and sustain a negative social construction of the sexuality of disabled women, resulting in the women developing a negative self-image of themselves, which I discuss below.

3.4.1 Negative self-image

Studies that have been carried out in the US and in Canada reveal that the negative social construction of disability which results in disabled women being perceived as asexual beings or invalids in need of medical attention, results in most disabled women losing their confidence on issues of sexuality. Referencing women with spinal cord injuries, a study carried out in the US revealed that disabled women often feel they lose their desirability or charm to impairment (Kettl et al., 1991). Such a perspective resonates with the findings of a study carried out in Canada which examined the sexuality of both disabled men and disabled

women who are disabled with Multiple Sclerosis (Barrett, 1999). The study highlighted that one's self-esteem and self-image is altered by disabling conditions that come with changes in both the social and sexual life of the disabled person. That is so because feelings about one's self are generally shaped by what people think they should be able to do and how others react to them.

In resonance with the above notions, sexuality itself is shaped by how one understands him- or herself, and how one makes sense of one's relationships with others, and how people fit into their cultural institutions (Steyn & van Zyl, 2009). Consequently, disabled women may among other things constantly worry about whether they would be worthy lovers or whether they will be capable of having an orgasm (Barrett, 1999). The result of such worries is the erosion of the sexual confidence of disabled women in a context where they feel they will be regarded by society as "sick" people (Basson, 1998). For example, examining the issue of sexuality for women who are disabled with spinal cord injury, a US study revealed that women, who acquire impairment as a result of spinal cord injury, often perceive that they would have lost at least 50% of their attractiveness to the impairment (Kettl et al., 1991). Such women lose their self-esteem and confidence to the extent that they give up on having intimate partner relationships before they even try.

A US study which examined the sexuality of people with psychiatric impairments revealed that the practice of engaging in sexual relationships involves a certain level of risk taking and susceptibility (Cook, 2000). As such, sexual practices may present challenges, particularly for those with limited self-confidence, as they fear that they may fail to control their emotions and behaviour. However, within US society, the same author notes a shift from a focus on "curing" impairments to an emergence of constructions of "recovery", which are aimed at securing a dignified existence for disabled people as well as their maximum self-determination and role-functioning. It is therefore not surprising that another US study (Mona, 2003) suggested the inclusion of "assistance with sexuality" on the list of tasks that encompass the job description of personal assistance service (PAS) providers and the identification of a personal assistant (PA) who is comfortable with the subject of sexuality.

Duties of a PA may, for example, include undressing and positioning the client for masturbation, placing the PA's hands on the client's hands to guide stimulation, helping two disabled clients to stimulate each other, guiding penis/vagina or penis/anal intercourse

(Mona, 2003), all in an effort to build the sexual confidence of disabled people. The argument is that disabled people are usually assisted with various tasks such as bladder/bowel care, and eating and menstrual care, hence sexual activity might simply be one more activity to add to the list. However, challenges may arise in relation to drawing a line between assisting with sexual activity and practically engaging in the sexual activity (Mona, 2003; Saxton et al., 2001). The difficulties may be caused by the fact that intimate work of this nature may have legal ramifications in a context where there are no clear guidelines and policy on assisting with sexual expression.

A study carried out in the UK about disabled women and motherhood revealed that in expressing their sexuality, disabled women are a sector of women who may choose not to have children, or women who may not want to miss out on the experience of having at least a single child (Thomas, 1997). Furthermore, disabled women may also experience challenges and anguish due to their own infertility or that of their male intimate partners or they may opt to single parent their children or to parent in different intimate relationships other than heterosexuality. However, the same UK study illuminates the omnipresence of disablism in the entire “voyage” from conception, pregnancy, and the process of giving birth to the child, right through to motherhood. Thomas (1997) states that based on normative assumptions which claim that disabled women are unable to be good mothers, both non-disabled healthcare staff and close family members and friends offer help without first of all enquiring from the disabled women about the kind of help that the women need, as further discussed below.

The work ethic of healthcare staff is usually that of “we know best” (Thomas, 1997, p. 640), hence disabled women are rarely consulted and they may also end up receiving inappropriate or conditional help in situations where “help” becomes “unhelpful”. However, Thomas and Curtis (1997) argue that such disempowering practices are likely to erode the self-esteem and confidence of disabled women as the women may begin to doubt their ability to be good mothers. The reality is that disabled women may end up having to negotiate a disabling social environment which is created by healthcare staff and which undermines their self-confidence, in contexts where the women are also vulnerable to sexual violence, as discussed below.

3.4.2 Sexual violence

Some Canadian and US studies have indicated that disabled women often suffer sexual violence at rates that are similar to, or more than that which are experienced by their non-disabled counterparts (Basson, 1998; Crawford & Ostrove, 2003; Nosek et al., 2001; Saxton et al., 2001). Sexual violence may include inappropriate behaviours such as attempted rape or completed rape, non-consensual fondling, indecent touching or offensive comments, showing of private body parts or pornography (ATVP, 2005). A US study refutes the myth that impairment may shield a disabled woman from abuse and argues that impairment actually reduces a woman's ability to defend herself against emotional or physical harm (Nosek et al., 2001). Whilst, as previously mentioned, all women are susceptible to sexual violence, there is a general consensus that impairment adds an additional layer of vulnerability to the experiences of disabled women. Crawford and Ostrove (2003) have attributed such an increase to a deficiency of social experience on the part of disabled women, which if combined with a desire to share intimacy makes the women easy targets. Along the same vein, perpetrators desire to exert power and control over all their victims but the increased levels of sexual violence on disabled women is instigated by the fact that abusers find disabled women to be simpler targets upon which they wield dominance (Nosek et al., 2001). Apart from being vulnerable to sexual violence, as discussed in this section, disabled women are also vulnerable to suffering rejection in intimate partner relationships, as discussed below.

3.4.3 Intimate partner relationships

A US study which examined the sexuality of people with psychosocial impairments revealed that the expression of one's sexuality and the establishment of intimate partner relationships form a primary part of the process of recovery following the acquisition of impairment (Cook, 2000). However, a study carried out in Canada (Basson, 1998) revealed that establishing new sexuality relationships for disabled women is not an easy task, given that it is common for disabled women to suffer rejection. Referencing the sexuality of disabled men and women, Shakespeare (2000, p. 161) states that "...the problem of disabled sexuality is not how to do it, but who to do it with". A study carried out in the US on the sexuality of women with visible and invisible impairments, indicated that the extent to which a disabled person is able to express or explore their sexuality is largely dependent on their prospects of meeting potential partners (Mona, 2003). The same authors cite challenges that include

environmental barriers such as architectural designs that are biased towards non-disabled people and monetary factors that include an inability to pay for transport expenses for travel to functions.

Considering the above challenges among others, most disabled women are left with no choice but to settle for abstinence, before they even attempt to bond sexually with another person (Basson, 1998). A US study revealed that people with psychosocial impairments prefer to deliberately suppress their sexuality because they are anxious about its “normality”, hence they end up internalising society’s condemnation of their sexuality (Cook, 2000). Cook states that outside of the medical fraternity, people with psychosocial impairments are usually scorned, made fun of and humiliated within American society where derogatory language may be used against them. In addition, invisible impairments are usually a challenge as women are often faced with an ethical dilemma in deciding how and when to reveal their true condition to a potential lover. Furthermore, whilst disabled women are conscious of the moral worthiness of not being deceptive to a loved one, they are also confronted with the fear of rejection, if a partner walks away when they have revealed the true nature of their impairment (Basson, 1998), hence they often have to make complex decisions in relation to self disclosure.

In the US, there are inadequate statistics alongside which the success or failure of relationships of sexuality of disabled women can be measured (Basson, 1998). However, Basson states that available statistics show that women who acquire spinal cord injuries during the course of their marriages often get divorced compared to those who marry after impairment. Furthermore, marriage unions that come after impairment have a potential of experiencing greater general and sexuality joy. A study carried out in the US revealed that a common impairment plays a significant role in influencing a couple’s development of a close intimate relationship, compared to engaging in an intimate relationship with a non-disabled partner (Crawford & Ostrove, 2003). Some US researchers have also indicated that some women report that impairment actually brought them closer to their partners than before (Barrett, 1999). Barrett (1999) cites the example of a woman who acknowledged that her impairment had actually resulted in her and her husband discovering the depth and diversity of their sexual feelings. In such cases one can say that impairment may bring a positive change in not only the sexual life of a disabled woman but to her entire life as well.

Summary

In this section I have discussed the sexuality of disabled women from an international perspective. It is evident that the negative social construction of disability may result in disabled women losing their self confidence on issues of sexuality. Furthermore, disabled women are likely to experience sexual violence at a rate that is similar to or more than that of their non-disabled counterparts. Disabled women also experience difficulties in securing intimate partner relationships given the fact that among other things, they usually suffer rejection.

Conclusion

In this chapter, I have reviewed literature which is pertinent to this study under four main headings: practices of sexuality in the local context; sexuality and GBV; prevailing discourses of disability; and the sexuality of disabled women from an international perspective. The absence of the voice of disabled women in local disability, treatment, rehabilitation, and sexuality literature is cause for concern. The paucity of studies on the sexuality of disabled women at both the international and local levels raises further concern. There is therefore a need to carry out research in such an under-researched area so as to be able to facilitate the voice and agency of disabled women, in an effort to contribute towards the accomplishment of positive individual and societal change. I discuss the methodology of this study in the next chapter.

CHAPTER FOUR

METHODOLOGY

Introduction

In this chapter I present the methodology which I used in undertaking this research. I outline my philosophical standpoint and I introduce the narrative methodology which underpins this study. Under such a methodology I discuss the interview techniques of the Biographic Narrative Interpretive Method (BNIM) which I used to generate data. I outline my approach to gaining access and the ethical considerations which I upheld throughout the study, as well as the process which I followed in inviting participants to take part in this study. In addition, I explain my choice of data management techniques and the levels of analysis that structure my approach to data analysis. In the same section, I explain this study's approach to data representation before I end the chapter with an assessment of the issues of quality and validity that are pertinent to this study. Below, I outline my philosophical standpoint.

4.1 Philosophical standpoint

In this section I outline my philosophical standpoint on the grounds that credible research work does not take place in a vacuum, but it is guided by fundamental ontological and epistemological perspectives. Ontological debates in research are often centred on two main platforms: either on the probability of a single objective reality that can be verified through empirical methods or the inescapable subjective multiple realities that are constructed socially (Guba, 1990). I side with the ontological platform that there are multiple subjective realities that are socially constructed. My choice of such a standpoint is guided by the aims and objectives of this study which I outline below, with the aim of reminding the reader of what they are.

4.1.1 Research Aim

This study sought to conduct an in-depth exploration of the experiences of sexuality of disabled women in Zimbabwe by means of their own voices. Through the facilitation of the voice of the women, the study explored the rich first-hand contribution that disabled women could make towards the understanding of their own experiences of sexuality.

4.1.2 Research objectives

- To describe the experiences of sexuality of disabled women in Zimbabwe.
- To recognise the main aspects of context and culture that impact and/or influence the experiences of sexuality of disabled women.
- To identify the impact of the intersection of various identity markers such as gender, culture and disability as well as power and privilege practices that influence the experiences of sexuality of disabled women.
- To contribute towards the development of indigenous theoretical formulations on disability and sexuality that are rooted in the African context.

Due to its exploratory nature, this study demanded an interactive process between the researcher and the participants; hence in line with my choice of the ontological position that I outlined above, I selected the epistemological standpoint of constructivism. Also known as social constructionism, constructivism regards all knowledge as constructed in that it is dependent on interaction, human viewpoints and social experiences (Schwandt, 2000). According to Schwandt, constructivism postulates that scientific knowledge is constructed by scientists and not discovered via the pursuance of strict scientific methods. As such we create models and ideas that enable us to make sense of experience, and we continuously review these constructions in line with new experiences within particular socio-cultural and historical contexts.

In line with the above perspectives, a researcher cannot be detached from the research process, because it is only through interaction with participants that the researcher can gain a meaningful understanding of their worlds (Campbell & Wasco, 2000). As proclaimed by Schwandt (2000), and Creswell (2013), I sought to position myself in the research process through an array of interpretative practices which would enable the world of the experiences

of sexuality of disabled women in Zimbabwe to become more visible. I therefore acknowledge that my own historic, ethnic and personal background played a role in influencing the manner in which I interacted with participants in their settings whilst I engaged the participants in dialogue in the research process. As asserted by Patton (2002), I also believe that by choosing to write in the first-person as researcher, my active voice illuminates my self-awareness role in this study.

Considering that the meaning-making process in narrative research arises from both interaction and dialogue (Hennink, Hutter & Bailey, 2010, Kathard, 2003; Krauss, 2005), I was also constantly attentive to the influence of my own language and social ideologies in the research process. The most important factor of narrative data is that it emerges from interview settings where meaning is jointly constructed through the interlocking of words and meanings in a process which creates “...*language as data* for the purposes of constructing interpretive meaning...” (Kathard 2003, p. 70). Since narrative research does not seek to test a precise hypothesis or to present to us pre-packaged stories, I braced myself to venture into terrains which I had not predicted and to also discover both similar and dissimilar data, thereby allowing myself as the researcher to be surprised by my own data.

I took heed of the assertion that a researcher’s engagement in dialogue does not mean that the researcher gives participants a voice or that the researcher speaks for participants (Ashby, 2011), hence I do not claim to be standing in such a capacity. Whilst it may appear like I am in a position of superior control as the writer of the narratives, the reality, as noted by Dhunpath and Samuel (2009), is that my position as the teller of the stories is framed within the cultural setting of this study, hence I am at the mercy of contextual social customs in telling the narratives. In any case, the power and limitations of both written and verbal language in the construction of social reality lies in the fact that language cannot have an exact or precise meaning; hence those who read and listen may interpret the version of a story from their own perspective (Ashby, 2011). However, the ontological/epistemological stance which I have chosen to guide this study resonates with the constructivist critical paradigm of inquiry, which I discuss below.

4.1.3 The constructivist, critical paradigm of inquiry

Paradigms or interpretive frameworks are characterised by belief systems that consign a researcher to a specific view of the world in a net which encompasses specific methodologies, epistemologies, and ontologies (Guba, 1990; Guba cited in Denzin & Lincoln, 2013; Patton, 2002). In resonance with the subjectivist, multiple realities standpoint which I have selected as outlined in section 4.1 above, the constructivist critical paradigm supports the co-construction of knowledge by the researcher and the research subjects in a natural world which uses naturalistic methodological procedures (Denzin & Lincoln, 2013; Patton, 2002).

In line with the assertion made by Steier (1991), I took heed of the fact that by aligning with the constructivist critical paradigm, I am co-producing as opposed to simply “discovering” the world of my research. Such a co-construction of knowledge is influenced by identity markers such as culture, class, gender, and race which impact on the manner in which people see or make sense of things and mould what becomes their reality (Campbell & Wasco, 2000). In addition, and as asserted by Patton (2002), the critical perspectives of the inquiry stretch beyond just seeking to study and comprehend societal issues, but it is a mode of inquiry which aims to critique and transform society.

The change oriented essence of a critical inquiry examines, among other things, justice and power relations within specific economic, racial, class and gender settings (Patton, 2002). Critical theoretical perspectives advocate for the empowerment of people, so that they may be able to rise above the limitations that are placed on them by gender, class and race (Fay cited in Creswell, 2013). In line with such a perspective and, considering that the experiences of sexuality of disabled women in Zimbabwe have not been subjected to any kind of research or narrative analysis prior to this study, I embrace a narrative methodological deportment which I discuss in section 4.2., below. I therefore use such a stance in my attempt to exhume the silent voice of the participants in the hope that opening up such voices would yield strength for the research subjects, as well as open up ears in the research arena.

4.2 Narrative methodology

Before I outline the narrative methodology which underpins this study I want to first of all reflect on myself as the researcher. I started my PhD studies in February 2013 when I was living and working in Harare, Zimbabwe for a capacity building NGO. I spent a considerable amount of time searching and reading literature pertaining to my area of study and in a few weeks I came up with a proposal. After receiving feedback from my supervisor I realised that there was need for me to focus the study and to narrow it down to a specific subject. After several drafts that were going back and forth between me and my supervisor I finally submitted my proposal in mid-2013 and I later presented my work at the Doctoral Quality Assurance Committee (DQAC) meeting in September 2013. Armed with encouraging feedback from DQAC and a then approved proposal from the Ethics committee of the University of Cape Town and later the Medical Research Council of Zimbabwe (MRCZ), I set out into the field to collect data.

Without any form of external funding in the first year I had to juggle travel between South Africa and Zimbabwe with limited personal funding and time. Considering that my participants were based in Zimbabwe and I was studying with the University of Cape Town in South Africa, I needed to maintain a presence in both countries, so as to benefit from among other things, the University library, one on one supervisory meetings and post-graduate writing workshops but at the same time taking care not to prematurely exit the research field in Zimbabwe. The scholarship funding which I began to receive in the second year of my studies was of great assistance. During my field work, I had to sit with participants for hours, building rapport and listening to their narratives. However, my conversance with the local Shona language and my familiarity with the research environment having been born and raised in Harare myself, made it easier for me to penetrate the research field.

As I had written in my study proposal, I knew that I had to perpetually engage in reflexivity throughout the study. Reflexivity stresses the researcher's consciousness of his or her own presence in the process of research (Barry, Britten, Barber, Bradley, & Stevenson, 1999). Whilst submerging myself in the natural settings of the study by interacting with the participants, as previously mentioned, I situated myself in the research context by integrating reflexivity throughout the research process to enhance the credibility of the research. Such a

stance resonates with the constructivist paradigm which has guided this research and which postulates that research cannot be detached from the values and perspectives of the researcher; hence an awareness of one's own perspectives is important (Patton, 2002; Gray, 2009). That is not to say that reflexivity is a neat process which does not come with its own risks of "unmasking" or "undressing" the researcher, thereby leaving him or her partly naked, to the extent that the researcher can be justly criticised (Clandinin & Connelly, 1994; Foster, 2016), but it is to say that reflexivity enhances the trustworthiness and quality of research.

Whilst I appreciate the value of reflexivity as an integral part of the research process, I was surprised when I realised that the process was to some extent painful. I was of the view that reflexivity would be a peaceful process, which would be similar to basking under the shed of a beautiful tree on a sunny day. However, as I outline later in Section 4.8 which discusses the quality and validity of the data, the reflexive examination of my own location within the research process felt more like a rebuke than a pleasantry. My natural work flare of "getting on with it" and working rapidly through tasks was challenged as I had to learn to slow down whilst I engaged in perpetual reflexivity in a project whose end appeared to be very far.

Closely linked to the concept of reflexivity is the circular nature of the research process (DiCicco-Bloom & Crabtree, 2006; Hennink, Hutter, & Bailey, 2011; Kathard, 2003). Although the research process of this study is presented in a linear fashion, I acknowledge the reality that the process progressed in a circular fashion in which the different stages of the process were constantly interacting. The process of analysing data for example did not have to wait until all the data had been collected. My intellectual intimacy with the data began from the first stage of data collection when I began to reflect on both the process and the generated data in initial data analysis. In addition, the analysis had also begun in the process of writing and publishing an article in a scientific journal (Appendix 19). The concept of reflexivity therefore enabled me to go back and forth on the continuum of the research process thereby prompting me to revise the process and to make further decisions as I deemed appropriate.

Metaphorically, qualitative research is described as a fabric which is characterised by its intricacy, miniature threads, numerous shades of colours, diverse textures, and several assortments of textiles that form assumptions and explanatory structures that bind the research together (Creswell, 2013). The structures of qualitative research are bequeathed with

various methods of qualitative inquiry which include grounded theory, ethnography, case studies and narrative research. Among such research approaches, I selected the narrative research methodology for reasons that I discuss below.

4.2.1 Narrative inquiry

In this section, I discuss the narrative methodology under an overarching qualitative research design as my choice of a methodology for this study. I chose such a design because in my quest to explore the experiences of sexuality of disabled women in Zimbabwe, I deemed the narrative approach to be the most appropriate, considering that, as postulated by Clandinin & Caine (2008), it is a way through which experience can be understood. Narrative inquiry seeks to study the lives of people, collect their stories through various data gathering techniques, record experiences and present the experiences in the order in which they occurred (Creswell, 2013; Gray, 2009; Polkinghorne, 1995). The narrative methodology permits the development of a contextual and intimate study of people's experiences over time as it seeks to make meaning of experience through conversation, dialogue and the researcher's ongoing participation in the life worlds of the participants (Clandinin & Caine, 2008). The close attention that the narrative methodology pays to experience as well as its orientation towards relational and ethical engagement adds to its appropriateness for the study of the experiences of sexuality of disabled women in Zimbabwe.

I also chose the narrative mode of inquiry because it does not only push the agenda of high profile scholarly dialogues, but it also allows those who are located at the periphery of society to take part in the creation of knowledge in academic circles (Canagarajah, 1996). The absence of the voice of marginalised groups in academic research implies an assumption that the marginalised are either not available to contribute towards theory formulation or that they are simply unimportant (Dhunpath & Samuel, 2009). However, Kathard (2009) argues that those who live at the peripheries of society are able to speak, albeit the paucity of ears that are willing to listen. Considering that disabled women form one of the most marginalised minority groups in the world, the narrative approach therefore held the potential to enable disabled women in Zimbabwe to contribute towards the construction of academic knowledge by narrating their experiences of sexuality.

In my attempt to accurately define narratives, I draw on the definition proffered by Wengraf (2013) which states that a narrative is a particular approach to giving an account that is oriented towards a story that outlines one event or one action after another in temporal sequence. This definition however, is an intentional way of narrowing the use of the word narrative, to avoid a generalised sense of using the term, which is likely to be lacking in chronological sequence and can end up referring to any kind of a broad array of self-narratives. By insisting that the experience must have gone into the biography of the narrator, narrative is differentiated from a simple reporting of things that have been seen by a narrator (Labov, 2002), such as seeing a boy herding cattle in the bush. The events that find their way into the narrator's biography are therefore those that are connected to an emotional and social evaluation arising from the speaker's raw experiences.

There is no standard way in which narrative studies are conducted, because narrative research is to some extent almost instinctive (Esin, 2011; Patton, 2002; Wengraf, 2001). I was therefore able to select, combine and define terms in the manner that I deemed plausible to the study. Considering that "story" is the term that is commonly used in place of "narrative" (Polkinghorne, 1988), I use the terms "narrative" and "story" interchangeably, to denote the narratives of participants who took part in this study. However, the word "story" may imply imaginary, falsified or fictional representations which are characterised by pretence and fantasy as demonstrated by the statement: "That is only a story" (Polkinghorne, 1995, p. 7). However, I borrow the concept of research stories from Polkinghorne (1988, 1995) as I excavate the narratives of this study. By so doing, I acknowledge the fact that research stories exhibit a particular culture's beliefs or view of the world, thereby authenticating fundamental goals and belief systems of that culture. Circumstances and locations within which narratives take place often include the cultures and institutional establishments of the participants (Esin, 2011; Polkinghorne, 1995). It therefore follows that the research stories of disabled women that I present in this study are embedded in significant belief systems of the Shona people of Zimbabwe.

The narrative approach has been criticised for representing stories that emerge from the single minds of individuals who are free to generate stories in a manner in which they want (Esin, 2011; Polkinghorne 1995). However, as indicated above, narratives do not emerge from single minds, but they are connected to cultures and constructions of institutions that are much bigger than one person (Esin, 2011). For example, I remind the reader that among other

beliefs about homosexuality in Zimbabwe, African people of Zimbabwe believe that homosexuals are of an “abnormal” sexual orientation because either they are bewitched or they are possessed with an evil spirit. The constitution of Zimbabwe also prohibits same sex marriages (Government of Zimbabwe, 2013). The result is a possible invisibility of different sexual orientations other than heterosexuality in the individual narratives of the experiences of sexualities of the people of Zimbabwe. As asserted by Esin (2011), the authenticity of stories is not just concerned with some independent reality of a single person, but the narratives create reality within the relations of the story teller, cultural perspectives and their outside world. Whilst narratives are undeniably embedded with calculated interests and imaginings of the narrator, narrators do not necessarily have to reproduce the past in the exact manner as it occurred (Riessman, 2005). The issue of the authenticity of stories is therefore summarised as follows:

Participants construct stories that support their interpretation of themselves, excluding experiences and events that undermine the identities they currently claim. Whether or not they believe the stories they tell is relatively unimportant because the inquiry goes beyond the specific stories to explore the assumptions inherent in the shaping of those stories. (Duff & Bell, 2002, p. 209)

Even if people were to fabricate their stories, the fact would still remain that all narratives illuminate and repose on the structures of a story that are held by a particular individual (Duff & Bell, 2002). As such narratives provide a window through which researchers can gain entry into the lives of people, their experiences and their belief systems. However, the broad narrative approach is embedded with different forms of narratives which include among others, epic poems, pictorial narratives, fictional narratives and biographic narratives. I decided to use the Biographic Narrative Interpretive Method (BNIM), which seeks to collect and interpret the real life experiences of people, as a way of understanding humanity (Roberts, 2002; Wengraf, 2001, 2013). I felt that selecting other narrative modes would not do justice to a comprehensive collection and representation of the real life experiences of sexuality of participants. For example, if I had used a fictional narrative approach I would have just made up stories about the experiences of sexuality of disabled women in Zimbabwe in the way that I wanted, without letting the participants tell their own story with their own voices and in their own way. I therefore outline the tenets of the BNIM interviewing

techniques below, which permit the exploration of the real life experiences of sexuality of disabled women through the facilitation of the women's own voices.

4.3 Biographic Narrative Interpretive Method (BNIM)

In this section, I introduce the BNIM interviewing method which I will further discuss in Sections 4.5.2 and 4.6.1 below. The BNIM approach emerges from the research work carried out in the early 1990s in Germany by Rosenthal and his colleagues (Chamberlayne, Bornat, & Wengraf, 2000). Such work emerged from that which was done by Fritze Schutze on story methods and analysis of texts. Schutze is a prominent character in advancing German methods of biography, in symbolic interactionism, in Glaser and Strauss' grounded theory methods of analysis and in methods utilised by the Chicago School for group work and supervision of students (Chamberlayne et al., 2000). In addition, the BNIM method has been used in various settings which include Rosenthal's exploratory studies involving life-story interviews carried out with Holocaust survivors and their families to determine the significance they attached to the past (Chamberlayne et al., 2000).

As a methodology, BNIM is rather unusual because not only is it a methodology in itself, but it also contains its own data generation (biographic interviews) and data analysis techniques (Jones, 2006; Wengraf, 2013). However, a researcher can still choose to use non-BNIM interpretive techniques even after generating data through BNIM interviews. I therefore used the BNIM interviewing techniques, but I did not use the BNIM data analysis approach. The BNIM data analysis approach uses a twin-track interpretation approach of the **lived life** and the **told stories**, which are then subjected to in-depth panel analysis (Jones, 2006; Wengraf, 2001, 2013). The heterogeneous panels are made up of four people from different disciplines for each narrative, who then subject each narrative to two sessions of analysis, by first of all formulating a hypothesis for each data chunk. I realised that the intensity of the BNIM data analysis approach, which takes up to a maximum of three BNIM interviews, would not allow me to analyse the entire data set drawn from the 16 BNIM interviews that make up this study. In addition, the three cases of the BNIM data analysis approach would inhibit a broader analysis of the diversity of experiences of sexuality of disabled women in Zimbabwe, in relation to different demographic attributes.

Beyond its exploratory nature, my decision to use the BNIM interview techniques was triggered by its ability to put together a huge number of Particular Incident Narratives (PINs) in the formulation of a very clear whole life story which consists of very rich data (Wengraf, 2001, 2013). The same author states that in comparison to semi-structured methods of narrative that are highly guided, the open narrative interview of BNIM permits or obliges the participant to provide what they select to remember and to narrate in their own way. As a result, a researcher does not only obtain the features of significant incidences and experiences, but he or she also obtains the additional insights and value that arise from the choices that are made by the interviewee in structuring their narrative.

A biographic narrative means that a person comes up with a story of part or of the whole of his or her own life and experiences (Jones, 2006; Wengraf, 2013). As mentioned above, in comparison to semi-structured narratives that are highly guided, BNIM's structure permits the participant to shape their own story and its structure. Attitude interviews and surveys tend to illuminate only the main and apparent perspectives of current times which resemble what Wengraf calls "official press releases" or what Jones (2006) calls "journalistic interviews". BNIM, through its focus on eliciting narratives of "past experience" rather than (just) copying down explicit assertions of present (or remembered) "position", facilitates the expression and detection of implicit and often suppressed perspectives, practices and counter-narratives at various moments in the past.

The BNIM approach is able to provoke experience narratives that transcend boundaries of self and society, to include the past, the present and the future, thereby accessing altered and mislaid times, locations, nuanced conditions of emotion and the manner in which people act and live (Wengraf, 2013). For example, the BNIM approach has been used successfully to explore the experiences of being an older lesbian or gay man living in a rural setting in South West England and Wales (Fenge & Jones, 2012) as well as in a Swedish study of migrants which explored the transnational trajectories of Iranians leaving Sweden (Kelly, 2013). The BNIM approach differs from ordinary life history narrative because it has three unique and separate sub-sessions whereas most life story approaches have one. The three Sub-sessions are embedded with unique restrictions which most other life story approaches do not impose or which they may even encourage. However, I will discuss later on in detail, in Sections 4.5.2 and 4.6.1, the BNIM interviewing techniques. Below, I present details of the process

which I followed to gain access and the ethical considerations that are embedded in this study.

4.4 Gaining access and ethical considerations

In this section I present the process which I followed in gaining access and the ethical considerations that guide this research.

4.4.1 Ethical approval

Both scientific and ethical considerations have an equally significant role to play in any research project (MRCZ, 2011). As such, in the first stage of this study, I gained ethical approval from the institution of study, the University of Cape Town (UCT) (Appendix 1). Considering that the targeted participants were of Zimbabwean origin, I sought and received further ethical approval from the Medical Research Council of Zimbabwe (MRCZ) (Appendix 2).

4.4.2 Autonomy

Autonomy is the capability of a human being to make well informed decisions without being coerced (Larijan & Zahed, 2008). In this study, I ensured autonomy by ascertaining that all participants were not lacking in decisional capacity. After giving all information pertaining to the research, my initial brief discussions with the participants enabled me to establish their ability to understand the research concept. I guarded against being coercive, or offering undue inducements which threatened to make people decide to do what they would not have done under normal circumstances. I used a sign language interpreter for deaf participants and I invested more time with participants who have intellectual impairments as it took them longer to understand the issues and to be able to repeat such issues back to me.

4.4.3 Informed consent

I obtained informed consent from participants after explaining to them what the study involved. Each participant received an information letter and a consent form and I allowed her 24 hours to think about and discuss the research with persons of her choice, whom she was also at liberty to allow to read the information letter and consenting form. A total of 11 participants signified their willingness to participate by signing the consent form and five participants who were unable to sign signified their consent to participate in the study by their

fingerprint imprints. By asking each participant to repeat back to me what the study was about, I was able to check that each participant had absorbed correct information. I gave the participants an opportunity to ask any questions or raise concerns which they had.

Informed consent was obtained in the language that each participant was most comfortable with, between Shona (vernacular) and English; because I am fluent in both these languages, no difficulties were experienced with language communication. I translated the letter of information to Shona (Appendix 7) as well as the Informed Consent form (Appendix 8). To accommodate visually impaired participants, the letter of information (Appendix 5) and consent form (Appendix 6) were translated to Braille. In addition and as previously indicated, I used a sign language interpreter to accommodate Deaf participants. I read out the letter of information and consent form to the five participants who were unable to read, in the language of their choice (vernacular), in the presence of a witness. Discussions were held in the language of each individual's choice.

Once I had constructed the narratives, I read out draft stories to participants who were unable to read. Because Shona (vernacular) is my mother tongue translating from English to Shona and vice versa, depending on the unique needs of each participant was easy for me. I also gave participants who could read the draft of the story to read, to ascertain if the participants were satisfied with the accounts that I had written. I primarily asked them to check if what I had written was making sense to them or if I had missed on any part of their experience, or if they wished to remove or to add any aspect of their experiences. Some participants edited the narratives for identifying features such as the name of their workplace or their boyfriend or husband's workplace and designation, or the institutions of learning where their children attended.

4.4.4 Beneficence

In terms of beneficence, this study has made a contribution to the development of indigenous theoretical formulations on disability and sexuality that are rooted in the African context. In addition, the study has contributed to the existing body of knowledge. Gilbert (2002) states that a person's narrative turns into an experience of an experience and it allows a person to reflect on their own life experiences. As such, I believe that participants gained knowledge of themselves through the summary of the results that I gave them. By openly sharing their experiences of sexuality, participants have become a voice for others in more or less similar

situations who have not participated in the research. The research did not give any direct monetary payments to the participants.

4.4.5 Non-maleficence

I upheld the principle of non-maleficence by ensuring that the participants were not exposed to any kind of physical harm. I clearly explained the risks or discomforts which I had anticipated to the participants. At the start of the study, I had anticipated emotional risks such as terror, annoyance or nervousness among the participants which could be caused by remembrance of bad memories in narrating experiences. I informed participants that I had made arrangements with a local NGO which offers psychosocial support and counselling and they had agreed to provide the service to participants for free. One participant explained that she sometimes suffers from depression when she remembers incidences about her divorce and how she lost two babies during separate child delivery processes. She explained that she had not been depressed by the interview but she requested to use counselling services in future if ever she was going to feel depressed; the NGO agreed to offer her such services for free upon her request whenever she wanted. I had also made arrangements for free legal advice and service with a local law firm; however, none of the participants requested legal service.

Most participants seemed to have been eager to narrate their experiences, and they explained that they considered the study to have been a chance of a lifetime. For example, Chipso said: *“I have been disabled with spinal cord for 16 years and no one has talked to me about sexuality, but to me sexuality is very important so this is a chance which I don’t want to miss.”*

I had also predicted that there could be the risk of participants losing income while taking time off work to participate in the study. However, it turned out that some of the participants were unemployed and some of them were running informal vending businesses. For the formally employed participants and those who were running informal businesses, I mitigated the risk of losing income while taking time off to participate in the study, by conducting discussions and interviews after working hours, and in some instances during weekends and public holidays. I programmed my time to suit that of each participant’s preferences.

I advised the participants that the definition of sexuality in this study was embracing all sexual orientations and that similar to all information that they would provide throughout the study, any information relating to same sex relationships would be kept in strict confidence in accordance with the ethics of research. Despite the fact that some researchers (Epprecht, 1998, 2013) have indicated that same sex relationships were prevalent in Zimbabwe in pre-colonial times, Zimbabweans have exhibited ignorance about different sexual orientations other than heterosexuality. In addition, same sex marriages are prohibited by law as articulated in the country's constitution (Government of Zimbabwe, 2013), thereby making it difficult for people of different sexual orientations to come out.

4.4.6 Confidentiality

For confidentiality purposes, I kept any information that identifies the participant (names, telephone numbers, email, addresses, etc.) in the strictest of confidence. The use of pseudonyms that were chosen by the participants themselves is part of the efforts to reduce the possibility of linking raw data to participants. I preserved all hard copy data and electronic back-up data in a locked cabinet to which I am the only person who keeps the key. I attained the protection of electronic data through the use of a password that combines numbers and letters and that is known to me only as the researcher, and also by logging off the computer each time it was not in use to prevent unauthorised users gaining access to confidential data. I also gave willing participants the opportunity to edit their narratives for confidentiality.

4.4.7 Justice

This study ensured justice by facilitating the voice of disabled women who are evidently located at the peripheries of society. It is likely that had it not been for this study, such women may have kept their viewpoints and experiences of sexuality to themselves and their voices may not have been heard. In addition, I respected the rights of the participants, such as the right for them to hold differing opinions, values, beliefs and attitudes from mine as the researcher. As postulated by Creswell (2000), I also respected and upheld the needs and desires of the participants in an effort to guard against the risk of this study resulting in being a burden to participants, whom I had invited using the process which I present below.

4.5 Inviting participation

In this section, I present the process that I followed in inviting participants to take part in this study, starting with my reflections upon exploring the research terrain. As part of BNIM self-training and in line with BNIM principles, I discuss the two practice interviews that preceded the first interview of my main study. I present the criteria for obtaining a sample for this study, before I end this section with a table that outlines the biographical details of the 16 disabled women who took part in this study.

4.5.1 Reflections upon exploring the research terrain

Before I started inviting disabled women to participate in this study, I was worried about the politics of my location as a non-disabled woman, trying to pierce into the experiences of sexuality of disabled women. Although I share a similar race, culture and gender affiliation with my then targeted participants, I was of the opinion that I was running the risk of being looked at as an outsider to the disability community and would perhaps be denied access to information on such a sensitive topic.

Having been born and raised within a Shona family in Zimbabwe myself, I was aware of the fact that it was very rare for the subject of sexuality to be openly discussed. Although I had met a disabled woman who had spontaneously talked to me about her intimate partner relationship before, I was doubtful about the possibility of finding other women who would be willing to talk openly about the subject. In Zimbabwe, the topic of sexuality is not only generally regarded as a private matter, but it is also a notion that is embedded with taboos, restrictions, abhorrence, disgrace and terror. I was therefore cynical about the “exemption” of my then potential participants from such contextual norms. However, I visited Disabled People Organisations (DPOs) in order to get a feel of the research terrain.

The National Association for the Handicapped (NASCOH) was extremely helpful in providing me with a list and contact details of DPOs that are established in Harare. I then visited a local DPO, where I met an official of the organisation who gave me an opportunity to discuss my intentions and the purpose of my study. The results of the meeting were valuable in yielding insights into the research terrain, thereby building my confidence and assuring me that I had chosen a significant and relevant topic. The official immediately

referred me to her friend who is disabled by Multiple Sclerosis; a woman who became my first participant for the practice interviews under the BNIM interviewing self-training programme which I discuss below.

4.5.2 Self training in BNIM interviewing

As I previously mentioned, before I delved into the main process of generating data for this study, I used the BNIM interview method to conduct two practice interviews. Compared to the spontaneous ordinary conversations that I had always had in both my personal life and in my work, I knew that researching people's life experiences would call for a systematic approach in extracting and handling their stories. However, devoid of any training in narrative research, I entered the universe of narrative inquiry without a compass and, having chosen the BNIM method of interviewing, I needed to develop systematic skills for exploring the deeper structures of participants' experiences. By then I had expanded my understanding of the subject of sexuality by reading relevant literature.

I structured the self-designed SQUIN design proforma (Appendix 9), which I sent to Tom Wengraf (BNIM expert in the UK) for comments and approval before application. In line with the requirements of the BNIM interviewing approach, I undertook two practice interviews before I attempted to apply the method on my main interviews. The purpose of the practice interviews was to enable me to develop particular skills such as note-taking, selecting and asking, and following up chosen narrative questions and obtaining feedback from the interviewee about the whole interview process.

The BNIM interview method consists of two key interviews, involving three Sub-sessions (Wengraf, 2013). The first interview is made up of Sub-session 1 and Sub-session 2 and the second interview is made up of Sub-session 3. In using the BNIM technique, I started by asking a Single, Initial Narrative-Inducing Question (SQUIN), in Sub-session 1, as illustrated in Table 1 below, to draw a wide narrative which is not interrupted. As postulated by Wengraf, I allowed each participant to regulate the narrative from beginning to end without asking questions, probing, directing or hurrying the narration. The point is to use the BNIM techniques to elicit the experiences of sexuality of each participant given that, as postulated by Clandinin (2006), people create meaning about their experiences through story telling. I outline the BNIM interview technique which I used in Table 1 below.

Table 1: BNIM interviewing technique

Sub-Session	Reason for Questioning	Questioning Format
Sub-session I Single Question Inducing Narrative (SQUIN)	Single, initial narrative-inducing question to elicit an extensive, uninterrupted narration (eliciting the whole story).	As we have discussed before, I am researching on the experiences of sexuality of disabled women in Zimbabwe. Could you please tell me the story of your life including your experiences as a disabled woman living in Zimbabwe, your intimate love relationships and sexuality involvements, including pregnancy and childbirth experiences that have been important for you up to now, begin wherever you like, I will not interrupt. I will just take some notes in case I have any further questions for after you have finished telling me about it all.
Sub-session 2 Follow up From SQUIN	To solicit more in-depth data about Particular Incident Narratives (PINs) as a follow up to Sub-session 1 (eliciting particular incidents).	<p>“You said ‘X’ do you remember any particular incident about that time when all that was happening?</p> <p>OR</p> <p>“You said ‘X’ can you give me a specific example of how that happened?</p>

Sub-session 3	Sub-session 3 is intended for the researcher to ask all additional questions that he or she may find relevant to his or her Central Research Question (CRQ) or Theory Questions (TQs)	Questions were drawn from Sub-session 2 after carrying out an initial analysis of the data collected in Sub-sessions 1 and 2.
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(Chamberlayne et al., 2000; Corbally, 2011; Wengraf, 2013)

I present details of the two BNIM practice interviews and the knowledge that I gained from such interviews below.

4.5.3 Practice interviews

As I previously mentioned, in carrying out the two BNIM practice interviews, I used the self-designed SQUIN design proforma (Appendix 9), and I interviewed women who fit this study's sample criteria. My objective of carrying out BNIM practice interviews was to pilot the study as well as to determine the appropriateness of the BNIM interview design for such a purpose. I intended to create a platform upon which improvements on the design could be made, based on the outcome of the practice interviews before conducting the BNIM interviews on full scale. Considering that BNIM interviews are expensive in terms of financing, effort, energy and time, the carrying out of practice interviews proved to be useful in assessing and situating the BNIM design within the research question of the study. I was therefore able to assess the suitability of the BNIM approach to answering the research question for this study at a very early stage of the research process. In addition, the practice interviews facilitated my own training as a BNIM interviewer.

I carried out the practice interviews with two women who were not part of my sample and who were also unknown to me: a 42-year-old woman who is disabled by Multiple Sclerosis and a 47-year-old woman who has a visual impairment. Undertaking a practice interview with a participant who is not known to the researcher ensures a genuine ignorance of their life and story and not a fabricated one (Wengraf, 2013). I completed the practice interviews in three sessions which lasted for about two hours each. At the end of such interviews, I asked each interviewee to give me feedback about her own perspective of how the interview

unfolded, and her viewpoint of the SQUIN. I also asked each participant to raise any issues that she wished I had asked about, but which I had not.

I undertook the practice interviews under the guidance of Tom Wengraf (BNIM international expert resident in the UK). I sent transcripts for Sub-sessions 1, 2 and 3 of the first practice interviews to Tom Wengraf and the feedback I got from him assisted me in improving on my interviewing approach. I carried out the second interview using the feedback which I had received in the first practice interview. It was only then that the BNIM expert felt I had mastered the concepts of the method and he advised me to begin the main interviewing process for the study. The practice interviews, feedback from the BNIM expert and feedback from the participants enabled me to learn the following factors:

1. Particular Incident Narratives (PINs)

I learnt that pushing for Particular Incident Narratives (PINS) was more important than writing notes, given the fact that I was digitally recording the interview. For example, feedback from the BNIM expert showed that I had lost 60% of the potential of the first practice interview because I had spent most of my time writing notes during the interview, instead of noting just a few points for developing PIN seeking questions in Sub-session 2. I had also asked questions on disability and neglected the participant's experiences of sexuality. As a result, I got a lot of information about her physical experiences of living with Multiple Sclerosis and very little about her experiences of sexuality, thereby defeating the purpose of formulating the CRQ and TQs to guide the interview process.

2. Contextualisation of Sexuality

I went into the practice interviews expecting to extract narratives of the participants' experiences of disability and sexuality, without giving enough thought to the social context within which the participants live. I learnt that ignoring the social context would be futile, given that the account of each participant indicated that her experiences of sexuality are not limited to her own body, but that she is part of a specific cultural and societal context. For example, although the story of the woman with Multiple Sclerosis was about her experiences of disability and sexuality, such experiences were embedded in a societal story of Black disablement in Zimbabwe, traditionalism and modernity in health and rehabilitation relationships. I therefore learnt the skill of not only soliciting Particular Incident Narratives

(PINs) that illuminate disability and sexuality, but to be alert to the societal context within which the participant lives in order to excavate a more meaningful, realistic and rich story.

3. Obtaining feedback from the participant on the whole interview process

Both practice interview participants expressed appreciation of the BNIM interviewing technique as well as the topic of the study. They esteemed the technique for allowing them to direct the interview themselves, and permitting them to talk about issues that were important to them and not issues that were important to me as the researcher; they also appreciated the fact that I gave them as much time as they wanted and I did not hurry or judge them. In addition, they valued the topic for creating a platform for them to talk about their experiences of sexuality for the first time. One participant compared the BNIM interview experience with a disability questionnaire research study which she had participated in before; she concluded that such a researcher had extracted bits and pieces of information from her and left without knowing her whole life story, which she would have preferred to talk about had she been given a chance. I discuss the sampling criteria which I used in this study, below.

4.5.4 Sampling criteria

At the conclusion of the two BNIM practice interviews, I instigated a rigorous process of recruiting participants outside of DPOs and of drawing a sample for my main study. Bearing in mind that the focus of qualitative research is not representativeness or data generalisation but the acquisition of comprehensive information about each participant (Creswell 2000), my focus was not on gathering a large number of participants for this study. I felt a sample of 16 disabled women would be manageable in facilitating an in-depth study that would be able to yield rich data. I explain why I interviewed 16 disabled women later on under the sub-heading of participant sampling in this same section. I used the snowball sampling technique to obtain an initial sample, out of which I had to purposively sample the participants, guided by the following criteria:

Willing informants

I sought participants who were willing to share their experiences of sexuality. I did not experience any problems with potential participants because every disabled woman I invited expressed willingness to participate in the study. They all explained that it was their first time to be engaged by a researcher on such a topic, which they all considered to be an area of their

greatest concern but which they felt was the most neglected. Revealing their feelings of marginalisation and vulnerability, all the participants felt that the study was offering them a chance to be listened to by someone who was truly interested in hearing their story.

Area of sampling

All participants were from Harare (the capital city of Zimbabwe). I chose such a geographical location because not only was it accessible to me, but also because of the fact that the vernacular language (Shona), which is widely spoken in Harare, is also my mother tongue. Harare was able to yield a view of both rural and urban experiences as all the participants (excluding one), who are now residing in Harare, were living in their rural village homes at one point or another.

Age range

I interviewed participants who fell within the age range of 18 to 65, because the study was of high relevance and importance to this age group. Such an age group's experiences of sexuality were likely to yield broader perspectives which could also include experiences of reproduction and motherhood. I excluded participants who were aged below 18 (the legal age of majority) and above 65 (the legal age of the elderly).

Coherent communicators

I included coherent communicators in the study and excluded non-coherent communicators because of the high demand of comprehensible communication demanded by the BNIM interviews. I mitigated the risk of engaging in skewed sampling by taking cognisance of the fact that participants have a right to choose their mode of communication (Cameron & Murphy, 2007; Kyle & Woll, 1988). As such, I included two participants who could communicate using sign-language. As previously mentioned, I used a sign language interpreter to facilitate communication between myself and the Deaf participants. In addition, I included people who are traditionally not considered to be coherent communicators, and in particular, those with psychosocial and intellectual impairments. Such participants proved to be eloquent in narrating their experiences of sexuality, save for the fact that those with intellectual impairments would occasionally go off topic particularly in the second Sub-session. In such instances I would allow them to take the narrative wherever they wanted to, until they had finished and then I would repeat the question and we would start all over again.

Nature of impairment

I took an inclusive approach which allowed all possible forms of impairment (physical, mental or sensory), within the age range of 18 to 65, to be included. Whilst albinism and epilepsy are shrouded with controversy with some people arguing that they are impairments and some saying they are not, this study has included such impairments. The UN regards albinism as a genetic disorder which is embedded with visual and skin impairments (UN report, 2013). In Zimbabwe, epilepsy is regarded as an impairment which results in psychosocial impairment (Mielke, Sebit, & Adamolekun, 2000). The World Health Organization (2015) defines epilepsy as a “...chronic non-communicable disorder of the brain that affects people of all ages.”

Participant sampling

As previously mentioned, following my initial recruitment of participants, I further selected participants using non-probability sampling methods in the form of purposive and snowball sampling techniques. I interviewed 16 disabled women over a period of eight months using the BNIM technique. I take cognisance of the fact that 16 appears to be a huge number for biographic narratives, but as I previously mentioned I entered the world of narrative research as a novice. Although my initial intention was to interview 12 women as I had outlined in my proposal, I later thought the best way was to interview more participants, choose the best stories and then discard the others. However, after transcription and data analysis, I found it difficult to abandon any of the stories, as I realised that what the disabled women had given me was more than just words. All the women had devotedly allowed me entry into the very intimate parts of their life worlds, and I felt ignoring some of the stories would be tantamount to disrespecting what the women had done and further marginalising their experiences.

Power dynamics and negotiation

Power dynamics form an integral part of all kinds of research, hence a researcher should not only be able to gain awareness of such dynamics, but he or she should also be able to negotiate power in the research process (Merriam et al., 2001). As such, whilst my power as a researcher facilitated my entry into the research terrain, the participants who took part in this study also negotiated power by naturally selecting the information which they wanted to share as well as determining the place and timing of the interviews, some of which took place in their own homes (Figure 1, above). Such a scenario concurs with the assertion made by (Merriam et al., 2001), that both the researcher and the participant engage in power

negotiations throughout the research process. By taking time to build and sustain rapport with participants, I was able to minimise the hierarchical characteristics of the research process, albeit taking care not to turn the research relationship into a friendship. The rules of the BNIM interviewing approach also affect power relations by giving more control to the participant than to the interviewer, as will be discussed later on in Section 4.6.1. I outline the demographics of the participants who took part in this study in Table 2 below.

Table 2: Biographic details of participants

Pseudonym	Age	Nature of impairment	Age acquired	Marital status	Number of children	Sexually active	Rural/urban experience	Education	Employment status
1. Gamu	20	Intellectual impairment	Congenital	Never married	0	Yes	Both	Nil	Nil
2. Rumbi	22	Visual impairment	16	Never married	0	Yes	Urban	High school	Nil
3. Vimbayi	22	Psychosocial impairment	7	Never married	0	Yes	Both	Nil	Nil
4. Tamara	28	Partial visual impairment	20	Never married	1	Yes	Both	Teaching diploma	Nil
5. Nyarai	29	Intellectual impairment	Congenital	Never married	0	Yes	Both	Nil	Nil
6. Mako	31	Epileptic	16	Divorced	2	Yes	Both	High school	Nil
7. Saru	32	Deaf	6	Divorced	1	Yes	Both	High school	Vendor
8. Danai	37	Albinism/ visual impairment	Congenital	Cohabiting	3	Yes	Both	Teaching diploma	Primary school teacher

9. Tari	38	Albinism/ visual impairment	Congenital	Widowed	1	Yes	Both	High school	Albinism project coordinator
10. Tsitsi	38	Mobility/ Polio/crutches	2	Cohabiting	2	Yes	Both	Nil	Vendor
11. Mara	42	Mobility/ Spinal cord Injury/	35	Widowed	3 plus 2 grandchildren	Yes	Both	High school	Vendor
12. Mayita	48	Psychosocial impairment	25	Divorced	2	Yes	Both	Two Diplomas/ general nursing and psychiatric nursing	House matron/ rehabilitation centre
13. Nyasha	47	Visual impairment	2	Never married	0	Yes	Both	High school and receptionist course	Receptionist

14. Chipo	54	Mobility/ Spinal cord injury/	38	Married	5 plus one grandchild	Yes	Both	High school	Disability Counsellor
15. Rudo	50	Deaf/partial visual impairment	Deaf at 2 Partial visual/im- pairment at 42	Divorced	0	Yes	Both	Primary school	Vendor
16. Tatenda	57	Intellectual impairment	Congenital	Divorced	0	Yes	Both	Nil	Nil

The average age of participants is 37. All participants are sexually active. All participants are not married except for one. All participants have had the experience of living in both rural and urban environments except for one. Nine participants have children and of that number two have grandchildren. Five participants have congenital impairment and 11 have acquired impairment, one participant became Deaf at the age of two and at the age of 42 she also became visually impaired. Five participants did not get any form of education. 11 participants are not formally employed.

In the following section, I outline the process which I followed in producing data using the BNIM interview method, as well as my reflections upon collecting the data.

4.6 Generating Data

Interviewing is rather like marriage, everybody knows what it is, an awful lot of people do it, and yet behind each closed door, there is a world of secrets... (Oakley cited in Allan & Skinner, 1991, p. 203)

4.6.1 The BNIM interviewing process

From the start of the interviews I had to be as honest as possible with participants, regarding the topic of my study and the study's purpose, whilst explaining to them that I was willing to answer any questions that the participants had. As opposed to hurrying to push my research agenda, I had to take time to build rapport with the women, in a local context which demanded that I accept boiled or open-fire roasted *chibage* (green mealies), *nzungu* (groundnuts) *manhanga akabikwa* (boiled pumpkins) and water whilst engaging in informal talk both before and after the interview (Figure 7, page 229). I realised that adhering with such traditional dimensions was critical in building relations and addressing research power dynamics that would see me reducing the hierarchical characteristics of the research process, albeit without turning the research relationship into friendship. I generated data using the three Sub-sessions of the BNIM interviewing technique as previously outlined in section 4.3 and explained in detail below.

Sub-session 1

In Sub-session 1, the participants talked about experiences and events which they considered to have been personally important to them. As postulated by Wengraf (2013), by opting to utilise the BNIM open narrative method I minimised control in Sub-session 1, in relation to the selection and handling of stories that the participants chose to tell or to ignore. Such an approach resonates with the qualitative research approach which is guiding this study. "We conduct qualitative research when we want to *empower individuals* to share their stories, hear their voices, and minimise the power relationships that often exist between a researcher and the participants in a study" (Creswell, 2013, p. 48). In keeping with the principles of the

BNIM interviewing techniques, I took care not to end sessions but to accept the endings as determined by the participants.

By affording participants the opportunity to end the interview in their own time and in their own way, I was able to assist them in maintaining their emotional stability and avoid spoiling the participants' gestalt and ultimately the research itself (Wengraf, 2001). Most of the participants ended Sub-session 1 with statements such as: "*I can just say that is my story...*" (Chipo), "*I can just say that's all I can say about my life...*" (Danai), "*So I can just say that is my story...I have tried to say all the things that have happened to me.*" (Mayita), "*That is just the story of my life...*" (Nyasha), "*I think that is what happened, I have said my life, I think that's just about it all...*" (Tamara), "*...that's just all about me that I can think of*" (Tari).

Sub-session 2

The principle in Sub-session 2 is to only ask questions about issues that were raised in Sub-session 1, in the order in which they were raised and using the words that were used by the narrator (Jones, 2006; Wengraf, 2013). That way, I was able to guard against breaking the participants' gestalt and ultimately spoiling the research. Whilst critics of the BNIM approach say there is a danger that the SQUIN may produce short answers, I found that the BNIM technique is capable of unpacking short SQUIN answers such as a *one and half page narrative in Sub-Session 1 to a 20-page rich narration in Sub-Session 2* (Appendix 10 and Appendix 11 respectively). The BNIM principle of questioning in Sub-session 2 is that the researcher should only ask questions about subjects that the interviewee talked about and not other topics that the researcher may be interested in. The agenda was already formulated by the participant in Sub-session 1, hence the Sub-session 2 questions arise from the participant's narrative of Sub-session 1 and they are not introduced by the researcher from outside of that sub-session. Wengraf (2013) states that any other questions that the researcher may want to ask have to wait until Sub-session 3.

Although I was still restricted by the above principle in Sub-session 2, I was still able to build on the material provided in Sub-session 1, to excavate additional story through asking Particular Incident Narrative (PIN) seeking questions. In resonance with BNIM principles, I identified good PINs in this study through their ability to enable a participant to re-enter such novel experiences and appear like she was partially re-living the incident which she was narrating (Wengraf, 2013). My objective in asking follow-up questions in Sub-session 2 was

to inspire the participant to provide PINs, about a series of events that would have occurred in her life in the past.

At the close of Sub-session 2, all participants had indicated an interest in having further discussions with me on the topic, describing the first two Sub-sessions as an experience of a lifetime. As such, I found it easy to request another interview with each participant for Sub-session 3 on a different day. Such an interview allowed me to probe issues that were of interest to me as the researcher or that were relevant to my Central Research Question (CRQ) or Theory Questions (TQs) that had not been addressed (Bingley, Brown, Payne, Reeve, & Thomas, 2008; Wengraf, 2013).

Sub-session 3

As postulated by Wengraf (2013), Sub-session 3 enabled me to meet with each participant again, to ask direct questions that are associated with the research agenda, to clarify ambiguous points and to gather more biographical data about each participant. In addition, I discovered that the advantage of Sub-session 3 is that it enabled me to ask questions in a manner that did not interrupt the narration by interjecting with questions as the participant told her story in Sub-session 1 and 2. It therefore follows that, as stated by Wengraf (2013), the objective of conducting three Sub-sessions is to make sure that the first narrative in Sub-session 1 is not influenced by questions, which will then be asked in Sub-session 2, thereby allowing rich data to be obtained in Sub-sessions 1 and 2 before other questions are asked in Sub-session 3.

The BNIM interviews lasted from between two to eight hours per participant. In addition to the time allowed for Sub-session 1 and Sub-session 2, I allowed an additional one hour to myself, to reflect and to write field notes immediately after the interview. Between Sub-session 1 and Sub-session 2, I shared refreshments with each participant and used this 5 to 15 minute break to prepare some of the PIN questions for Sub-session 2. Sub-session 3 took place after 1 to 8 weeks following the initial interview (Sub-session 1 and Sub-session 2), as primarily dictated by the circumstances of each participant.

I discovered that by the time I returned to the participants for a Sub-session 3, the circumstances of some of the participants had changed. For example, in the course of carrying out the interviews, a participant with a psychosocial impairment went through a one-

month long period of mental relapse and another participant with an intellectual impairment had been hospitalised after falling and hurting herself. In such cases, I had to wait for the participants to get well, before continuing with Sub-Session 3 of the interview. I also shared the transcribed data with participants, to enable them to check if what I had written was a correct representation of what they had said. Considering that I situated myself in the research process by integrating reflexivity throughout the research process, I reflect on my experiences of generating data, below.

4.6.2 Reflections upon generating data

All women whom I invited to participate in the interview readily accepted the invitation. However, some women did not appear to be promising interviewees at the beginning, particularly those with psychosocial impairments. Such women forgot about the interview appointments in the first place and it would take me almost an hour of waiting before they were ready for us to start the interview. As a way of showing their seriousness and respect for the interview process, some participants would ask me to wait while they bathed and changed their clothes so that they would look smart for the interview. However, by the time we would finally start the interview all the women would gladly open up and I would start to think that the long waits were worth it after all.

All participants explained that it was their first time to be afforded such a platform to talk about their experiences of sexuality; hence they regarded it as a chance of a lifetime. My own assessment was that the participants felt safe with me, given the extent to which they were willing to share the most explicit and intimate details of their experiences of sexuality during the interviews. It is difficult to assign such an outcome to a singular dimension; hence I take it that the manner in which the participants constructed their experiences was largely dependent on not only me being the woman that I am, but also on the nature of my interaction as the researcher with the participants. Although I had gained considerable confidence from my meetings with the DPO officials, practice interviews and feedback from the BNIM international expert, I discovered that meeting each participant was a unique experience which aroused a bit of anxiety in me just before meeting the interviewee for the first time.

I had not interacted closely with people who have some of the impairments before; hence in some instances I was anxious about the manner that they would expect me to behave. I was

preoccupied with trying to decide on strategies of interaction that would not in any way offend or insult the participant. However, it was the warm welcome that I received from each participant that made me feel at home. The positive attitude of the participants helped me to relax and to realise that I was actually pursuing a study which the participants greatly appreciated. I felt more confident as the participants kept explaining to me that sexuality was an area of their greatest concern.

My initial fears that the women would perceive me as an outsider and deny me information were unfounded. I felt deeply trusted when, in illustrating a point, some women would take off their clothes to show me scars or impairment aids that would have been hidden under their clothes or their anti-retroviral drugs for their HIV positive status. In some instances participants would ask me to sleep over at their places of residence; since I was not prepared for such offers I would courteously and tactfully decline. The women explained that they appreciated the thoughtfulness of the study in reaching out to them on a topic which they felt was neglected but was very important in their lives. However, I realised that the diversity of the nature of the women's impairments demanded a different kind of prowess and demeanour in undertaking each interview.

The interviewing experience was not the same with each participant. Interviewing visually impaired participants demanded the translation and distribution of the informed consent form and sheet to Braille before the interview, but it naturally did not present any challenges with verbal communication. Deaf participants presented challenges with verbal communication because I could not speak sign language, hence I had to use a sign language interpreter and adapt to a sitting arrangement that was designed by the participant and the interpreter to suit the nature of the impairment. However, I discovered that regardless of the kind of impairment, every woman was hungry for a platform upon which they could articulate their experiences of sexuality. The women bemoaned the silence that is maintained on the subject in Zimbabwe, arguing that such silence is detrimental to the well-being of disabled women.

On reflection, I realise that all the participants took the whole interview process very seriously and made great efforts to articulate themselves well, although as previously mentioned and in a few instances, some women, particularly those with intellectual impairments would go off topic. The women did not appear to be uncomfortable with answering any of the PIN questions that I proffered, as they all appeared free, eager and

relaxed to talk. I started to realise that BNIM is a powerful technique, as I pushed for lots of PINs, which yielded a lot of rich information which is relevant to my CRQ and TQs. Before I started using the BNIM technique (which I had never used before) I was sceptical about its ability to extract narratives of the nature that I was pursuing, but all the interviews yielded rich and relevant data.

All the participants were pleased with my return for a Sub-session 3 and they explained that they were happy to have been afforded an opportunity to update me on the changes that had taken place in their lives from the time of Sub-session 1 and Sub-session 2. Some of the experiences of sexuality that the women shared were very difficult for me to absorb hence I sought psychological therapy, as I explain later on in Section 4.8 under the subheading of reflexivity. I realised that after each interview, I found it difficult to get each woman out of my mind as I would be constantly “hearing” the voice of the woman as if she was still recounting her story and tears would run down my cheeks. In instances where a participant reported trauma, I would find myself experiencing the effects of the trauma albeit in a secondary fashion.

On days when I conducted an interview, I would find it difficult to do anything else during that day as I would feel emotionally exhausted at the end of each interview. I would therefore block a whole day for each interview, after which I would go home and find myself processing all that would have happened during the interview. The interviews reminded me of some of the traumatic experiences that I had confronted in my own life and consulting with the psychologist was useful in so far as it created space for me to explore the issues that arose from the interviews as well as those that arose from my own life as the researcher. However, it was the difficult experiences that were shared by the participants, coupled with the relentless attitude of hope which they displayed, which further ignited my strength to carry on with the study, in which I managed and analysed the generated data, as discussed below.

4.7 Data management and analysis

In this section I present the data management and analysis approaches which I embraced in this study.

4.7.1 Data management

With the permission of participants, I systematically recorded (digital recording) and documented responses. I used active listening skills to reflect upon BNIM interviews. I took written data field notes which included observations of both verbal and non-verbal behaviours as they manifested. I complied with the requirement of the BNIM technique which demands the recording of four sets of data field notes as follows:

Table 3: Data field notes for the BNIM interviewing technique

1. Data field notes immediately after the interview	Appendix 13
2. Data field notes whilst doing polished notes	Appendix 15
3. Data field notes whilst writing up the transcript	Appendix 16
4. Data field notes whilst reflecting on the first 3 sets of data field notes	Appendix 17

4.7.2 Generation of transcripts

I personally did a verbatim transcription of each interview in full before I started analysing the data. Although I could have hired a professional transcriber I felt that I would have more confidence in the data if I personally transcribed it, given that I had collected the data myself as the researcher. Such an approach enabled me to develop an intimate relationship with the data, albeit the demands of the approach in terms of my time and concentration (with one interview spanning an average of 5-6 hours and 15 single spaced typed pages). In line with an assertion made by Easton, McComish, and Greenberg (2000), I had to listen and re-listen to the recording, and read and re-read the transcripts in order to check and re-check for accuracy before I could start analysing the data. However, by personally transcribing the interviews it became easier for me to draw texts for proper quotations from the data and to move quickly between the interviews.

However, I noted that the process of transcribing was not as straightforward as I had anticipated, considering that digital recording does not capture the subjective experiences of each interview. Nevertheless, to mitigate such a loss, I allowed myself one hour immediately

after each interview to sit in the car, away from the participant but before leaving the interview site, to write de-briefing notes in my journal which in BNIM terms are called “free-associative notes”. These notes include among other things issues such as: what it felt like to be with the participant, how she behaved, what she was wearing, moments of joy, awkwardness, boredom or irritation and the setting of the interview environment. According to Wengraf (2013), BNIM prescribes that the notes should be capable of bringing back the “lived experience” of the interview, 12 months or even 12 years later or more. I therefore wrote down everything that I observed about the interview, the participant and the environment. However, given the sensitive nature of my topic, I experienced emotional challenges with transcription which I later discuss in section 4.8 under reflexivity. However, I had to subject the data which I had generated as represented by the transcripts to three levels of data analysis, which I discuss in the following section.

4.7.3 Data analysis

The purpose of data analysis is to process data in such a way that it is able to provide answers to the original research questions (Durrheim, 2006). However, qualitative studies produce large quantities of information which need to be condensed, labelled and examined through varied data analysis approaches (Lacey & Luff, 2007). Since there is no compulsory standard way of analysing qualitative data (Agersnap, Bentzon, Hellum, Stewart, & Ncube, 1998), I borrowed practice from the assertion made by Lacey and Luff (2007). I therefore selected my own combination of data analysis methods, which suit the research aim and objectives of this study, the type of data which I generated and the insights that I obtained during field work, as discussed below.

Borrowing practice from Hancock, Ockleford, and Windridge (2009), I decided to analyse the data at three levels: the first level is descriptive and it focuses on presenting what a participant says without trying to make any meaning out of it; the second level analyses the content of transcripts by identifying common patterns across the 16 biographic narratives that make up this study and identifying themes and the relationships that exist between the themes; the third level is the deeper level of analysis which is interpretative – it is concerned with analysing what the participants meant by saying what they said. In other words, I sought to describe the findings at the first level, to articulate what such findings mean at the second level and to understand the findings at the third level. I felt that analysing the data at a single

level would narrow the potential of this study to provide a rich and robust analysis which lays a strong foundation for this study to make a significant contribution to the existing body of knowledge.

At the first level I took heed of the advice given by Polkinghorne (1995) and I used narrative analysis to focus on the particular by generating whole life stories that reveal the uniqueness of an individual case as well as provide an understanding of both its peculiarity and distinct complexity. Although this study is made up of 16 biographic narratives, I paid attention to the assertion made by Chase (1996) and selected four whole narratives from the larger collection so that I could fully present such narratives as robust examples of the processes of study in Chapter 5. Although the biographic narratives are unique to each participant, I chose narratives that encompass elements of the experiences of sexuality which reoccur in most of the other narratives.

At the second level, I used the analysis of narratives approach to move from the particular to the general, thereby generating common themes from the collected stories and also illuminating the relationship that exists between such themes. Building on Bruner's work on paradigmatic and narrative cognition, Polkinghorne (1995) draws out the differences between narrative analysis and analysis of narratives and states that narrative analysis produces stories and analysis of narratives draws out themes and relationships between the themes from storied data. The third level of analysis which is embedded in the discussion of findings is a deeper layer of analysis which seeks to make meaning out of the perspectives that the women collectively share and value within the genre of telling their stories. All three levels of data analysis generate valuable knowledge, albeit of different cognitive forms.

Before I go into detail about the distinct data analysis approaches which I used, I would like to remind the reader that I discovered that the process of analysing data did not have to wait until all the data had been collected. By writing four sets of BNIM data field notes, as I illuminated in Table 3, in Section 4.7.1 above, I was able to reflect on both the process and the generated data and to carry out an initial analysis of the narratives before completing the process of generating data by noting emerging themes. In addition, and as previously mentioned, the process of writing and publishing an article in a scientific journal enabled me to test and formalise the analysis approach (Appendix 19). The processes of data collection

and that of data analysis were therefore running parallel to each other. However, I discuss my first level of data analysis in the following section.

4.7.4 First level analysis

In this section I discuss the first level of data analysis which was largely influenced by the work of Bruner (1985) on narrative cognition and subsequent work by Polkinghorne (1988, 1995), on narrative analysis. Narrative cognition seeks to bring together the different aspects of specific action into a harmonious whole in which each aspect is linked to the main purpose of the action (Bruner 1985). Narrative cognition therefore, is not concerned with drawing out themes of commonalities from different stories, but it is concerned with collecting individual stories.

Embedded in narrative cognition is narrative analysis, which denotes a group of methods of dealing with different kinds of storied format scripts by bringing together different elements into convergence by means of a plot (Polkinghorne, 1995; Riessman, 2005). Whilst narrative analysis is able to reveal the experiences of individuals, it also illuminates the cultural processes that shape such experiences in society (Chase, 1996; Esin, 2011). As such, it is more about bringing events together to form a plot which illuminates the elements that are pertinent to the story (Hatch & Wisniewski, 1995). Narrative analysis is capable of linking people's biographies and social structures as well as the personal and political (Esin, 2011). In addition, narrative analysis can pave the way for researchers to comprehend the complex lives of human beings and their relationships as well as enable researchers to explore the manner in which people can recall, construct and turn their experiences into stories.

I discovered that participants were not presenting their stories in chronological order. I justified such a scenario by noting the proclamation made by Hatch and Wisniewski (1995): that human experience is disorderly, and it therefore fails to meet a carefully designed, neatly packaged and tidy story. As such, I was only able to arrange the stories in a clear sequence, after the stories had been told, bringing together related events that were sitting in distant positions within each narrative (Durrheim, 2006). Such ordering was essential, because as postulated by Esin (2011), it enables the linking of life events in a fluent way, which makes sense to a particular audience through narrative analysis.

My major attraction to narrative analysis was instigated by its interpretive tools, which are crafted in such a way that they allow researchers to scrutinise issues, occurrences and people's lives from a holistic perspective (Daiute & Lightfoot, 2004). In addition, it illuminates the diverse, interconnecting issues that structure and bring to the fore the relationships that exist between individuals and society (Chase, 1996; Daiute & Lightfoot, 2004). However, people do not live their lives through experiencing one by one disconnected events or shaping happenings through one by one sentences, but they instead, shape single sentences and events into broader frameworks (Bruner 1990). In narrative research terms, such broader structures are represented by a "plot", which is a framework within which people seek to define and comprehend the link between the events that occur in their lives and the choices they make.

The Narrative Plot

I used the concept of the "plot" as articulated by Polkinghorne (1988), as an analytical thread that puts order to the stories that I collected in this study, by identifying and binding important parts of the story and weaving through such parts to put the narrative in order in accordance with the importance of singular events. Polkinghorne (1988) states that the purpose of the plot is to convert an inventory of events into a representative whole by illuminating and identifying the role that some events play in creating a story and its final outcome. Stand-alone events are not narratives, but the experiencing of such events turns them into stories which become a pathway through which we dialogue about the universe, our lives and ourselves (Esin, 2011). Events are chosen, arranged, linked and assessed as significant for a specific audience; those who tell stories are simply making deductions about the world and the experiences that are embedded within it (Riessman, 2005). To illustrate the extent to which a narrative plot joins specific human behaviours and events into interconnected facets of a coherent whole, Polkinghorne (1995, p. 7) gives the example of two events:

"The king died; the prince cried."

Left to stand on their own, each of the above events describes two isolated occurrences. However, when put together into a narrative, fresh levels of relationship connotations emerge, at a point where the plot begins to produce meaning. In story format, the crying of

the prince is an outcome of the death of his father. Connecting the two events enhances our understanding of both of them; the son cares for his father and the father's death pains the son. Narrative displays the significance that events have for one another. According to Polkinghorne (1988), failure to realise the importance of a plot would leave each event in a discontinued and detached state, thereby limiting its clear-cut identification or its sequential position.

I drew tenets of the story plot from Polkinghorne (1995) and used such tenets as a primary analytic tool for producing biographic narratives, four of which I present in Chapter 5. I therefore considered the cultural setting in which the stories occurred and I also took into consideration the relations between each disabled woman and other people in her life. Furthermore, I illuminated the choices made by each participant in relation to the actions she takes to accomplish particular goals. By so doing, I sought to fully understand the participant's own perspective and view of the world, given the fact that she is not a passive hostage who is battered by her context but, rather, has the capacity to alter the scene. I did not separate each disabled woman from her historical experiences, given the fact that whilst a person's past experiences may not determine their future actions, a human being's past experiences often continue into their present life. In addition, I marked the narratives with the principle that the product of a narrative analysis is a unique story, which consists of a bounded temporal period of a beginning, a middle and an end (Polkinghorne, 1995). As a final check, I drew the events of each story line together into a systematic whole which is plausible and understandable, before I took the final step of writing the story.

Considering the above notions, my representation of the four narratives in Chapter 5 is not just a collection of descriptions of events, but it is indicative of the manner in which I used the plot as "glue", to systematically bring together occurrences into a complete whole. In the process of linking the data elements together, and identifying their significance in contributing to the story line which seeks to answer the research question, it became clear to me that in some cases there were some gaps. However, taking cognisance of the BNIM principles, I would always go back to the participants to ask for further information that would enable me to fill such gaps in Sub-session 3 or thereafter and I subsequently moved from the first level of analysis to the second and third levels, as discussed below.

4.7.5 Second and third level analysis

In this section I discuss the concept of “analysis of narratives” which represents my second level of analysis of the 16 narratives that make up the entire data set of this study as well as the third level of analysis. At the second level and as proclaimed by Riessman (2005), and similar to the approach that is used by grounded theorists, I generated 16 stories and inductively created conceptual groupings from the entire data set. I did not apply the fully fledged grounded theory method of Glaser and Strauss (1967), but by taking its inductive elements and also following guidelines which are given by Braun and Clarke (2006), I adopted an approach which is driven by the data and which does not try to fix data into pre-designed codes or my own preconceived ideas as the researcher.

An inductive way of analysis is premised on the assumption of an open and flexible process in which patterns and issues arise from the data (Kathard, 2003; Braun & Clarke, 2006); a platform which I found useful given the novelty of this study and the study’s focus on the unique experiences of sexuality of disabled women in Zimbabwe. However, that is not to say that I liberated myself from my epistemological or theoretical commitments which I outlined in Chapter 1 and Chapter 2 respectively. But, it is to say that bearing such commitments in mind; I came up with a detailed analysis of the themes that emerged from the data, through an unbiased process of discovery, which took me from the particular issues to the general issues across cases. However, I also borrowed practice from Bergstrom (2010), hence my analysis was not only driven by the nature of the data, but it was also driven by my theoretical awareness. As such the meaning of the analysis acknowledges the dialectic link that exists between data analysis and theoretical perspectives.

The “analysis of narratives” falls within the ambit of paradigmatic cognition where instances are classified as belonging to specific categories or sub-categories in which the elements are perceived as possessing similar characteristics (Polkinghorne, 1995). For example, the category of human beings may contain children, the elderly, or the middle-aged. Each category is differentiated from the other by its distinct characteristics which are defined by Polkinghorne (1995) as the group’s “specific difference”. The concentration of the paradigmatic way of thinking is therefore on the characteristics that make each element a part of a particular classification in terms of similarities. As such, the result of paradigmatic analysis is accounts of themes that exist across the stories or in classifications of kinds of

stories, locations or characters. The thematic approach is valuable for finding commonalities and differences across cases (Riessman, 2005); hence I approached cross-case analysis through constant comparison between the cases.

In drawing out themes for this study I began by reading and re-reading the data and noting down preliminary ideas as proclaimed by Braun and Clarke (2006). I then separated words and sentences across the narrative texts in a process of manually coding the data. I coded all the sections of the transcripts that related to the CRQ and the TQs. By identifying common patterns, I collated the codes into possible themes, putting together all data that is pertinent to each possible theme. Drawing advice from Braun and Clarke (2006) I then reviewed the themes: “Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis” (p. 87).

As asserted by Braun and Clarke (2006) I realised that the analysis of narratives does not take place in a linear fashion. The process therefore saw me going backwards and forth between the coded data, the entire data set and the analysis of the data in relation to the CRQ, the TQs and the reviewed literature. At one time it appeared as if the analysis would not come to an end, as I continued to improve on the names and details of each theme to make them more meaningful and clearer, as well as improving on the wholesome story that the analysis would tell. I generated four main themes from my analysis of the 16 narratives that make up the full data set for this study and I present such themes in Chapter 6. The presentation depicts both main themes and the sub-themes that emerged from the main themes.

Although the analysis of narratives employs paradigmatic analysis as is common in other qualitative research studies, what differentiates it from other approaches is that it takes stories as its primary data for analysis (Polkinghorne, 1995). However, whilst paradigmatic analysis may draw out similarities among classifications of data that identify specific happenings within the data, it also illuminates the relationships that exist among the different classes of data. The power of the paradigmatic approach lies in its ability to cultivate general knowledge about an assemblage of stories. However, in the process of developing such knowledge, the distinctive and specific aspects of each story are lost. Polkinghorne (1995) states that compared to narrative analysis, analysis of narratives can only produce distinctive categories, whereas narrative analysis produces whole stories. I therefore endeavoured to enhance the credibility of this study by using both the “narrative analysis” approach and the

“analysis of narratives approach” before embarking on the third level deeper layer of analysis, as discussed below.

The constructs that encompass the third level of analysis as embedded in the discussion of findings represent a deeper layer of analysis which is interpretative in nature. As postulated by Hancock, Ockleford, and Windridge (2009), such a level of analysis is sometimes called a latent level of analysis which is focused on understanding the accounts of participants. The third level of analysis therefore seeks to make meaning out of what the disabled women recount as their experiences of sexuality within the broader context of their social location. As such, whilst my focal point in the second level of analysis was on the precise meaning of the data at surface level (Braun & Clarke, 2006), at the third level of analysis which derives from the second level, I sought to examine and to make meaning out of the fundamental ideologies and concepts that underlie what the disabled women jointly value and share within the genre of telling their stories. However, the narratives that I subject to data analysis give rise to issues of representation which I discuss below.

4.7.6 Representation

I take cognisance of the assertion made by Mantzoukas (2004) and state that the distinctive philosophical standpoint which I outlined in Section 4.1 is intertwined with what is ultimately represented by the text of the research. My adoption of a non-positivist standpoint in this qualitative inquiry means that this research is an original piece of work which has been undertaken by me as the researcher. Taking heed of the assertion made by Chase (1996), I admit that I have in some ways influenced the research project throughout. I have therefore made an effort to illuminate my involvement throughout the research process. As such, I acknowledge that the narratives that I present are co-constructed given that they arise from my interaction as the researcher with the participants and are influenced by that interaction. The nature of voices that are used in this study is outlined and discussed in Section 4.8 which reflects on issues of quality and validity in this study.

However, I concur with the assertion made by Mantzoukas (2004), which states that the reader plays a part in the result of the study as he or she is also required to participate actively in it. That is not to say that I do not acknowledge my ever-present interpretation as the researcher in the presentation of this thesis but it is to say that I am conscious of the fact that,

as postulated by Mantzoukas (2004), readers may recreate the findings of the research, thereby ending my representation as the researcher, and beginning that of the reader within the findings. As such, to guard against the risk of providing a poor base of interpretation for the readers, I provide as much detail as possible, including a great deal of the disabled women's voice in representing their narratives. Although readers may have different views to my interpretation, my in-depth provision of detail is meant to make it easier for readers to understand the foundation upon which my interpretations that emanate from my process of data analysis arise, as reflected on below.

4.7.7 Reflections upon data analysis

During both data collection and analysis I was so amazed by the way in which all the women gave explicit details of their experiences of sexuality with their intimate partners. It dawned on me that the Deaf participants had not been deterred by the fact that I was using a male sign language interpreter, having confronted problems in my efforts to secure a female sign language interpreter in the research area. My fears that the Deaf participants would not open up in the presence of a person of the opposite sex turned out to be immaterial, as the Deaf participants proceeded to eloquently give intimate details of their sexual experiences. I started thinking that perhaps the Deaf participants were pleased with the fact that a non-disabled male was paying great attention to them and he was listening very carefully to what they were saying; considering that nobody including their family members had expressed particular interest in listening to them in general or in giving any level of importance to their experiences of sexuality. In addition, I thought that perhaps it would be beneficial to interview the sign language interpreter in order to explore his response to the experiences of sexuality that were told by the Deaf participants and the situation he found himself in; but then I realised that such an interview would fall outside the scope of this study. However, the voluminous amount of data that I ended up with was testimony to the fact that all participants were starved of a platform to speak about their experiences of sexuality and, indeed they considered the podium provided by this study as a chance of a lifetime. I was surprised by the quantity, quality and content of my own data, which however gave rise to the issues of quality and validity, which I discuss in the following section.

4.8 Quality and validity

Validity represents the extent to which an account is accurate in representing the realities of participants' social occurrences and its credibility to them (Schwandt in Creswell & Miller, 2000). My choice of the validity procedures which I applied in this study were influenced by my paradigm assumptions. I discuss the validity techniques which I applied in this study below.

First/Third person writing

Throughout the thesis, I chose to write in the "I" to denote my first person writing as the author of the thesis. I also wrote in the third person as the teller of the stories of participants to portray the disabled women's experiences of sexuality. In line with the assertion made by Webb (1992), first person writing enabled me to pursue reflexivity and to avoid being deceptive by hiding my own thinking and activity in knowledge construction. In any case, by drawing from my chosen ontological/epistemological standpoint, which calls for the engagement and not the detachment of the researcher, I argue that I have not been an obscure researcher or a neutral bystander who has an unidentified voice. I made decisions and exercised choices that influenced the research process and which I openly and honestly discuss through a reflexive approach, thereby acknowledging my personal contributions to my work.

On the other hand, by writing the narratives of participants in the third person I acknowledge that as the researcher I am not a character in the stories of participants, but I stand in the position of reporting what the disabled women themselves recount through their own voices about their own experiences of sexuality. Although I am the writer of the stories, I make an effort to report the stories in as much the same way as the disabled women recounted the narratives. As stated by Orges (2011), I keep to telling the stories of disabled women without sliding in the "I" in the narratives of participants, thereby using pronouns such as "she", "disabled woman", "disabled women" or "participant(s)" to portray the viewpoint of the participants. In line with an assertion made by Orges, such an approach enabled me as the researcher to comprehensively explore the diverse features of the experiences of sexuality of participants whose accuracy I verified through the process of member checking, which I discuss below.

Member checking

One of the most important ways of determining or reinforcing the credibility of a qualitative study is through member checking (Doyle, 2007). In upholding the principle of confirmability, I used member checking to test the data which I had collected as well as its interpretation whilst negotiating meaning with participants. I took specific accounts and themes to participants and asked them to check whether they saw what I had written as a true reflection of what they said. In other words, I was asking the question: “Did I understand this in the same way you meant it?” (Carlson, 2010 p. 1105). In addition, and for purposes of upholding the principle of confidentiality, I also asked them to check for identifying features that could link the data to the participant as well as to check whether I had represented their voice in the way they meant.

To those who were unable to read and those who preferred that I read out to them, I read the contents of the transcripts, and for the four participants who wanted to read, I gave them hard copies of the transcripts. By so doing I provided participants with an opportunity to review what they had said, and in the process I was able to ignite them to provide additional valuable information as well as to make amendments and deletions to their stories. The objective of member checking is to build the view of the participants into the research by respecting and supporting them, to ensure that they are not further marginalised (Creswell & Miller, 2000). For example, one participant remembered how she had endured physical abuse from her alcoholic husband and during member checking she provided additional information of how she had managed to claim her personal agency and asked her husband to choose between their marriage and his love for beer, thereby bringing to an end a long period of physical abuse.

During member checking, other participants challenged issues to do with their family structure and some added further explicit details about their experiences of sexuality. However, this is not to say that member checking is a panacea which totally eliminates participants’ claims that the researcher misunderstood some statements but as noted by Doyle (2007) it does reduce such risks. Doyle states that member checks have been criticised for carrying the risk of influencing the researcher to take a distinctive position. However, I guarded against such a risk by making every effort to reflect the individual participant’s actual “realities”.

Thick, rich description

In relation to transferability, I took advice from Ponterotto (2006) and Robson (2011) and provided dense and comprehensive descriptions to enable those who are interested in transferability to have a solid framework for comparison. I therefore used rich, thick accounts to describe the findings, thereby illuminating the complex net of social and cultural relationships within which the emotions, patterns of thinking and actions of participants take place as they experience their sexuality. This is meant to help readers to visualise participants' settings with the intention of factoring in an element of shared experiences. I avoided the provision of excessive and unnecessary information that threaten to drown the reader to the point of losing focus on the primary aim of the study, whilst at the same time I circumvented descriptions which lacked detail. I believe that my use of a threefold approach to data analysis enhances the dependability or credibility of my research findings.

Reflexivity

To enhance the credibility of this study, I kept a field journal throughout the research process. This journal served as my record of what was happening throughout the study including interpersonal relationships and events that occurred, where they occurred, when they occurred and how they were responded to. As I previously mentioned, I integrated the reflexive approach throughout the research process. Given the sensitive nature of the topic of this study, I realised that the process of generating data was as emotionally draining as the transcription and data analysis processes. I found that writing each transcript and reading each transcript during data analysis was like reliving the experience of the interview. As I previously mentioned, I would constantly "hear" the voice of the participant and "see" the participant with my own eyes as if I was still at the interview location.

I detached from my own family and friends and I preferred to spend long periods of time on my own, "digesting" all that would have emerged from the interviews. At home, I would retreat to my own space on the pretext that I was studying, when in fact I would just be gazing at the ceiling and weeping. As a novice narrative researcher, I at one time thought that the best thing was for me to complete the research project as fast as I could, in order to ease myself of the pain that I was going through, but I realised that it being a PhD study, such an approach was not possible, given the demands, requirements, ethics, rules and etiquette which I had to follow for such a level of study. After carrying out each interview and during

transcription and analysis, I would constantly find tears running down my cheeks and I would find it difficult to sleep during the night.

As I indicated in Section 4.4., I had anticipated emotional risks among the participants, but the possibility of the emergence of aspects of a “shared history” with participants had not occurred to me prior to commencing the study. As a first time researcher of both the methodology and the sensitive topic, I had not expected that I could hear things that could shock me or distress me and others that would remind me of my own past traumatic experiences, as the researcher. For example, I remembered experiences in which I had luckily survived two rape attempts; one when I was aged nine, when a male relative who at the time could have been in his forties unsuccessfully attempted to rape me and I was saved by the arrival of his wife. The other rape attempt was from my male Science teacher when I was 14 years old. I was in a Science laboratory in high school and I saved myself by screaming; the teacher could have been in his fifties at the time.

Although I tried hard to contain my emotions, I was embarrassed when, after I had completed generating data, I shed tears during a session in which I was reporting on the progress of my study at a Doctoral Quality Assurance Committee (DQAC) meeting in the presence of other Health Sciences PhD students and some academics at the University of Cape Town. At that time, my primary supervisor directed me to seek psychological help. I also realised that I needed both personal and professional “care” although I was ill prepared for both at the time. The services of the psychologist that I sought helped me to confront and deal with issues that had been raised by participants in the interviews, as well as issues that were coming out of my own life as a result of the study, and I began to feel better after a few months.

Stemming from my own methodological experiences, I side with the observation made by Dickson-Swift, James, Kippen, and Liamputtong (2007) that qualitative researchers who explore sensitive topics may require therapeutic support so that they may be better able to handle the issues that may emerge from the research. There is therefore need to create a platform, within academic circles, upon which researchers of sensitive topics may examine the emotional aspects of their studies as well as receive appropriate and timely support. My feelings and emotions during the period that I was undertaking this study served to remind me that even though I am the researcher, I am just as human as my participants. It therefore follows that whilst it is important to consider the risks of exposing participants to harm in

research on sensitive topics, the issue of the risks and welfare of the researcher should not be regarded as an insignificant issue or a later addition to the research process.

Conclusion

In this chapter I have presented the methodology that I used in undertaking this research and illuminated my reflex approach throughout the process. I outlined my philosophical standpoint and introduced the narrative methodology which underpins this study. I have discussed the process which I followed in inviting participants to take part in this study and the interview techniques of the Biographic Narrative Interpretive Method (BNIM), which I used to generate data. I have explained my choice of data management techniques and the three levels of analysis that structure my approach to data analysis. I have also outlined my data representation approach and an assessment of the issues of quality and validity that are pertinent to this study. I present the findings of this study in the next chapter.

CHAPTER FIVE

NARRATIVE ANALYSIS

Introduction

As mentioned in Chapter 4, I present in this chapter four biographic narratives that represent my first level of data analysis, which was largely influenced by the work of Bruner (1985) and Polkinghorne (1988, 1995) on narrative analysis. My representation is indicative of the manner in which I used the plot as “glue”, to systematically bring together occurrences into a complete whole. Although the narratives are co-constructed, the direct quotes from the narratives of participants “speak” for themselves as they represent the manifest layer of analysis of what the participants actually reported (Hancock, Ockleford, & Windridge, 2009). In this first level of analysis I do not attempt to make meaning out of what the disabled women said because the level represents a descriptive mode of the data. However, to strengthen my data analysis approach, I begin to search for meaning out of what the women recounted at the second level of analysis, which is presented in the next chapter. In other words, I offer a descriptive representation of the experiences of sexuality of participants in this chapter, and in the next chapter I begin to articulate what such experiences mean, albeit in a context in which I draw occurrences from all the 16 narratives that make up the entire data set of this study.

I foreground four narratives in this chapter, because presenting the full text of all the 16 narratives that make up the entire data set of this study would not only make the chapter too long, but it would also divorce the thesis from its academic requirements. I also felt that relegating all the 16 stories to the appendices would be tantamount to further marginalising disabled women and their experiences of sexuality. The four narratives are selected as robust examples of the voices and experiences of sexuality of disabled women in Zimbabwe. Although the biographic narratives are unique, the stories encompass some common elements that occur in the remainder of the narratives which are not included in this chapter, but whose parts I will include in my analysis of narratives across the entire data set of 16 narratives, in the next chapter, thereby offering a more indepth analysis and a “bigger picture”.

The four narratives that I present in this chapter are of disabled women who have different kinds of impairments: 1) Tsitsi has a polio induced physical impairment and she uses crutches; 2) Nyarai has intellectual impairment; 3) Danai has albinism and visual impairment; and 4) Chipso has a spinal cord injury induced physical impairment and she uses a wheelchair. In presenting the stories in this chapter, I highlight important occurrences, actions and people that may have influenced each disabled woman's experiences of sexuality in the past, in the present and her vision for the future. The participants chose their own pseudonyms; hence I use such names to preserve their original identity. Below, I present the biographic narrative of Tsitsi.

5.1 Tsitsi's story of searching for love and belonging

When I first met Tsitsi in 2014 at her residential place in one of the poorest high density suburbs in Harare, I felt she was carrying the apathy of a woman who was indifferent, angry and bitter. As such I was trying to be careful not to upset her in any way, fearing an emotional backlash on my sensitive topic from a woman who appeared to have been battered and shattered by life itself. Her dwelling was roofed by fragmented asbestos sheeting and it was threatening to fall on its own inhabitants. Upon introducing myself, Tsitsi's mood switched from that of indifference to that of a warm welcome. She explained that she considered the interviews to be a chance of a life time and a platform that would enable her to reveal a story that she had kept hidden throughout her life. She afforded me interviews on different days at her place of residence after she had on each occasion sent her boyfriend away. On all occasions, Tsitsi proceeded to recount her narrative with great composure, thereby contributing greatly to making the interviews a success.

Village life

Tsitsi is a 38-year-old woman, whose infection with polio at the age of two left her with atrophied legs of different lengths. *"My mother said I had polio because I did not get immunisation for polio."* Tsitsi was raised by **mainini** (her mother's younger sister) in her maternal rural village. Her father was absent and her mother was working in the city as a nanny and Tsitsi's mother was not allowed to live with children in the servants' quarters that were allocated to her by her employers of White European descent.

She started menstruating at the age of 13, reusing a few pieces of cloth during such times. *"No one was teaching me about menstruation but if I make a mistake and spoil my dress mainini would beat me up."* Tsitsi was unable to start school with other children of her age because her guardian did not think it was important for Tsitsi to go to school because she is disabled. Tsitsi did not engage in early adolescence dating because she spent her early years of puberty under the watchful eye of **mainini** who kept her busy with various household chores that would make **mainini's** life easy. However, when Tsitsi was 16 years old, her grandmother took over Tsitsi's guardianship and she sought to enrol her to start school at a local village primary school. Tsitsi says:

My grandmother sent me to school when I was 16 years, but the school was very far and I did not have a wheelchair or crutches for walking. I just stopped after a few days of trying so I am not educated.

At the age of 19 Tsitsi was raped and impregnated by Farai, a non-disabled man who lived in her village neighbourhood.

Farai told me that I am beautiful and he loved me, but I was not sure whether to love him or not, and then I started to love him, because I was thinking that he loves me for sure. Then one day I met him and he said, "let me show you a shorter route to your homestead". He pulled me into the bush and fondled my breasts. Farai raped me, he broke my virginity and I got pregnant...but he refused to marry me.

When Tsitsi later discovered that she had fallen pregnant as a result of the rape, she informed Farai about the development. *"I told Farai that I was pregnant and he refused to marry me; he said I can't marry you because **uri chirema chemukadzi** (you are a disabled woman)."* When Farai's family suspected that Farai could be tempted to formalise his relationship with Tsitsi in a marital union (given that she was now pregnant), the family vehemently opposed the possible union.

*The family was saying No! He should not marry a disabled woman, she can die when she is giving birth and she can become **ngozi** (avenging spirit) which is bad for the family. They were also saying that a disabled woman will give birth to a disabled child.*

Tsitsi continued to stay with her grandmother until her pregnancy had reached full term and she delivered a baby boy. *"I was happy because people were saying disabled people cannot give birth to children...but I saw that now I have a son, my mother bought baby clothes and my grandmother helped me to take care of the baby."* However, after Tsitsi had delivered her first son her mother attempted to facilitate Tsitsi's "sterilisation".

...my mother took me to the clinic in the village...She said...can you remove the body parts on her body...so that she will not get pregnant again because she is disabled? The people at the hospital...refused.

Farai resurfaced in Tsitsi's life when she was 21 years old and when their first son Tino was 14 months old.

...he came back and he said he was very sorry and he loved me and he said now he wanted to marry me and to take me and the child to his mother. I was very happy that Farai was asking for forgiveness and reconciliation. But he raped me again and I became pregnant again, but he went to marry another girl who was not disabled. I gave birth to a disabled son and my mother and my grandmother helped me to look after my children.

When Tsitsi gave birth to a physically impaired child, the healthcare staff at the clinic started to call each other from all corners of the clinic to witness what they described as a strange object that had been delivered by a disabled woman.

...they called each other to say, "Come and see this weird thing that is here". His legs were not straight; they were bent like this (going to the back and touching his back). I said God what is this? God, now people think I have more evil spirits...but then again I was happy that I now have two sons.

City life

At the age of 33 and when her sons were 12 and 10 years old respectively, Tsitsi got assistance from a Disabled People Organisation (DPO) that had visited her village. She left her children with her grandmother and she moved to the city to take a two year dressmaking course at the DPO in ¹Bulawayo. *"After two years they said your dressmaking course is finished so go back to the village and use your course to work for yourself so that you give us a chance to help other disabled people."*

Tsitsi had fallen in love with city life and she was reluctant to go back to the village. She had not done well in the dressmaking course due to her lack of primary level education, hence she felt she was not well equipped to start a dressmaking business. *"When I went there I did not know numbers and how to measure, so for me to make clothes for people I could not do it because the measuring was hard."*

¹ Second largest city in Zimbabwe after Harare (the capital). It is located in the province of Matabeleland.

Tsitsi decided to look for employment opportunities in the city.

...I did not want to go back to the village because I had seen that life in the city is better for me as a disabled woman because the water is from the tap so I don't go to the well. Also, I don't have to plough fields and fetch firewood from the bush.

In seeking to establish herself in the city, Tsitsi sought assistance from Farai's brother.

I went to his brother and I said, "Please can you help me to find a job so that I can work and look after my children." The brother said, "It's ok! I can help you to get a job but you have to have sex with me first." I was very desperate but it was hard for me to have sex with his brother so I said, "I can't do it because you are the brother to the father of my children" and I went away.

Tsitsi decided to set herself up as an informal vegetable vendor, using a donation that she had received from a local Roman Catholic Church.

*I saw that now I was raped and now I have two children and I have to work for my children, but I saw that now I can't get a job because I am disabled and I am also uneducated, so I said, let me use this ten dollars **yandakawana kuRoma** (which I got from the Roman Catholic Church) to start to sell vegetables. I found a place to stay and later I moved my children from the village to stay with me. Well-wishers sent my son to hospital and his legs were straightened and he was given a wheelchair. I was happy.*

Whilst living in the city, Tsitsi continued to search for relationships, love and belonging.

In the village, no one liked me, everyone hated me because of my disability and, everyone was just saying I am a useless person. In the city I saw that other disabled people were having also their love relationships and I also desired to have one.

Dating in the city

Tsitsi narrated that although disabled women and disabled men may share a common identity marker of disability, some disabled men are insensitive to the disability of women. She gives an example of an intimate relationship that she had with a physically impaired boyfriend.

He was in a wheelchair but he said to me, "What do I want a disabled woman for? I don't like disabled women because they are useless in bed so I go for able-bodied women because they are good in bed".

She further illuminates her gendered perceptions of disability by comparing the sexual attitudes of some men towards disabled women.

I learnt that it doesn't matter if a man is disabled or not, they are all the same. A disabled man can be worse than an able-bodied. This disabled man said, "I am more superior to you because I have a penis and you don't have one, even if I am on wheelchair, but I have a penis". Disabled men can also be promiscuous, much more than able-bodied men.

Tsitsi narrates her views about the sexual attitudes of some non-disabled men towards disabled women.

An able-bodied man just wants to take off my clothes to check if I have a vagina, I think in his mind he will be thinking, "This woman is disabled so does she have a vagina? Can she have sex? Let me take off her clothes and see, let me also have sex with her to see if she can do it".

Dead or alive

When Farai heard that Tsitsi had set herself up in the city, he unexpectedly appeared at her informal vegetable stall, with the intention of coercing her into a sexual relationship.

...he came back and said he loved me and we should get back together. He said, "I want to give you another child, I have given you two boys, I want to give you a girl child now." So I said to him, "No! I don't want you!" I refused him because I saw

that he could rape me again. He went back and on his way he was struck by lightning and he died.

The death of Farai did not make a difference to Tsitsi and her children. *“For him to be dead or alive it’s the same for me and my children. He did not talk to them or give them anything. I got help to look after them from my mother and grandmother and other people.”*

He gave me AIDS

When Tsitsi attained the age of 35 she began to have an intimate partner relationship with Mudiwa, a non-disabled man whom she claims infected her with HIV.

I can’t forget Mudiwa because he came and he gave me AIDS. He started to have sex with me and then he said we should have a baby. So I said to him I heard that if people want to have a child they should go for AIDS test. So he said it’s not important. He said to me, “So you think you don’t have AIDS, you should know that you have AIDS because I have given you AIDS already.”

Tsitsi thought that Mudiwa was joking until a few weeks later when she heard that Mudiwa had fallen ill and he had died at a hospital in his rural village in Mount Darwin in the northeast of Zimbabwe.

So for the first time I said, “Let me go and have an AIDS test”...They tested me and they said, “You are HIV positive”. So I started to cry, I cried and cried and cried. I was now thinking about Mudiwa who had died and, I thought he knew that he had AIDS, that’s why he was talking like that.

When she told her mother that she was now HIV positive, Tsitsi’s mother shouted at her by saying; ***“Ropa rako rakabatwa EDZI ko makondomu kwanga kusina here?”*** (Your blood was found with AIDS, were there no condoms?). Tsitsi reasoned that her mother was failing to conceptualise her predicament, because most men who want intimate relationships with her are non-disabled men who are capable of overpowering her because of her physical impairment. *“They overpower me because I am disabled and it’s up to them to use condom or not and my mother does not understand...the men they don’t want to use condom.”*

Enjoying our sex

Tsitsi esteems her year-long relationship with Nhamo, her unemployed boyfriend whom at 54 is about 16 years older than her.

I now have HIV but I have had this man now for one year and I think he is better, because others would come and have sex with me and go...sometimes for one day and sometimes for a few days. Nhamo is 54, but he is not working, we use the money that I get from selling vegetables...We enjoy our sex

When she met Nhamo, Tsitsi advised him of her HIV positive status and that she had been living with the virus for about two years: “...I told him that I have AIDS. Then he looked at me and said No! I don’t think you have AIDS because you look very well.” To convince Nhamo that she is indeed HIV positive, Tsitsi showed him her medical records and her antiretroviral medical drugs. “So I showed him my cards from the hospital and the ARV tablets that I take, and he said it doesn’t matter he still loves me.” Tsitsi recounted her unprotected sexual experiences with Nhamo.

Akati handingadye siwiti nepepa rayo nekuti hangingazonzwi kunaka kwayo kwese nekuda kwepepa (He said I can’t eat a wrapped sweet because I won’t be able to enjoy its full sweetness because of the wrapping). *I told him that the nurses had said that because I now have AIDS I should not have sex without condom, but he said, it doesn’t matter, just forget about those nurses and AIDS and let’s just enjoy our sex. I think he is a nice man, he is not worried about my AIDS, my disability or condoms or anything like that.*

Tsitsi went back to the HIV testing centre to advise the healthcare staff about Nhamo’s standpoint in relation to their sexual relations. “They said I must bring him to the centre for testing, but he refuses. He just wants us to have sex and not to worry about anything.” Although Nhamo had refused to take an HIV test, Tsitsi’s conscience remained clear, given that she advised him of her HIV positive status at the start of their relationship. “But for me I went into the open because I didn’t want to lie to him that I don’t have AIDS.”

Tsitsi gave further explicit details of her sexual experiences with Nhamo.

*Nhamo's penis is very big because "anemutupo weMbizi weMakorekore" (he is of the Zebra totem of the **Makorekore Shona** descent)...If Nhamo is on top of me and I say I am tired I don't want to have sex anymore, he doesn't stop...two times he had sex with me until I was bleeding. He says "if you sleep with a woman and she doesn't bleed, then you are not a man"...Now he is asking me to find **mushonga wekupfeka** (herbs that tighten the vagina) and I am not doing it because I am afraid that his big penis will tear my vagina apart and I also think that now I have AIDS so I may get sick.*

Tsitsi expresses general happiness with her intimate partner relationship with Nhamo, albeit the threat of the return of Nhamo's ex-wife.

But this man has brought so much peace in my life. He is a nice man. His ex-wife has returned. She said, "I had gone away to South Africa because I didn't love my husband anymore, but now I want him back because if he gets sick you won't be able to care for him because you are disabled".

She recounts her feelings about the possibility of Nhamo returning to his ex-wife.

I am now close to him because we have lived together in my room for a full year. I don't know what's going to happen, maybe he will go back, maybe he won't, but so far he has said he will stick with me. I think that he loves me so I will be sad if he leaves and I also fear that since I now have AIDS it may be hard for me to get another man.

I am not a prostitute

Tsitsi sums up the lessons that she learnt throughout her experiences of sexuality and her vision for the future.

"What happens is that a man will come and say, "I love you" and, then I say, "It's Ok!". Then we have sex and then he dumps me. Even if I meet him the following day he will just look sideways as if he doesn't know me and he behaves as if he has never seen me before. So this forces me to find another one, because I will be feeling lonely.

So I end up sleeping with too many men, not because I am a prostitute but because they just come and go.

Bearing in mind the advice that she got from the HIV testing centre, Tsitsi illuminates her desire to safeguard her health and well-being by sticking to one intimate partner.

I don't want to change boyfriends because now I have AIDS, so I am thinking that my future life will be better if I just have one partner and not Change! Change! Change! But Ah! If Nhamo goes back to his ex-wife, then I will look for a good man who can marry me in future.

The above narrative indicates that Tsitsi desires to engage in safe sexual practices and she is resilient in searching for a stable, reciprocal, intimate partner relationship.

Epilogue

Tsitsi's narrative is about resilience and a persistent search for love and belonging in a heterosexual context where she challenges the myth of asexuality. On the one hand Tsitsi acknowledges the oppression that characterises her experiences of sexuality from her childhood years, but on the other hand she depicts her sense of power, agency and hope. In constructing her identity Tsitsi regards disability as a major social life attribute which frames the oppression that characterises her experiences of sexuality. The narrative also indicates Tsitsi's belief that it is her duty as a woman to sexually satisfy her male intimate partner even at the expense of her own health and well-being. Tsitsi's narrative depicts the intersection of disability, gender, culture, class and poverty in framing her experiences of sexuality. I present the narrative of Nyarai who has an intellectual impairment, below.

5.2 Nyarai's story of love and an aspiration for marriage

I first met Nyarai in 2014 at the psychiatric rehabilitation centre where she stays. With her natural long black hair which was braided in an African way, a white T-shirt, a long blue skirt and brown plastic slippers, she looked very pretty and cheerful and she did not exhibit any signs of impairment. It was only when I started talking to her that I realised that she was struggling to express herself and she would sometimes go off topic. I therefore needed to be extremely patient with her if the interviews were going to take place or to be successful. However, on all interview occasions, Nyarai was very happy to see me and she would hug me with joy before we would retreat to a private room where we would have the interviews. Although Nyarai would remain silent for a little while (as if she was not going to speak), she exhibited a lot of innocence and thoughtfulness as she articulated her experiences of sexuality. Her positive attitude, cooperation and attentiveness contributed to making the interviews a success.

My family

Nyarai is 29 years old and she has an intellectual impairment. Her grandfather and her mother passed away when she was 15 years old and whilst she was still living in the village. At the age of 21, she lost contact with her immediate family (her father and four brothers) when she was enrolled into a rehabilitation institution by her aunt.

My grandfather died and my mother died. My father is alive. My grandmother and my brothers live in the village; they can't visit me because they are busy. They are poor so they don't have money to come here to see me. We are five in our family, four boys and me. I am the only girl in our family. I didn't go to school. I came here for a long time ago. I came here because I have BP (Blood Pressure), swollen legs and sore throat.

Menstruation

Nyarai highlights the experiences of her menstrual periods.

My period pain is very painful, so I use cotton. My aunt buys cotton for me then she brings it here. My mother was sick and then she died of stomach pain. But she taught me that when I wake up I must sweep the house and cook and wash clothes. I wash my

clothes when I am menstruating. I put the cotton wool in the bin then I find a nice dress and I wear the dress and I wash the dress then I rinse it and then I hang it.

Sex in the chicken run

She illuminates her love for her boyfriend and her marital intentions.

My boyfriend is called Mavhu. He is drinking tea. I love him very much. We want to marry so that we go and live with his mother in their village. We are getting married in April. I know that Mavhu loves me because he gives me his juice and popcorn. We have sex in the chicken run.

Nyarai reveals the relationship restrictions that are placed on her at the rehabilitation institution where she stays.

But don't tell Mrs Chido or Mrs Tafi. I am not allowed to love anyone, so they say if you love someone, it's not allowed so we will punish you. So if they know they will punish me and they will not give me food. I have sex with my boyfriend in the chicken run at 4, it's the time for gardening so that is the time that we have sex.

Jealousy

Nyarai illuminates her suspicion that her boyfriend could be developing an intimate interest in another woman.

He is giving his chips and biscuits to Maidei, and now he doesn't give me. Then I asked him and he said Maidei is just his friend and I am his girlfriend. Then I said, "So why do you have sex with me?" and then he said, "Just leave that alone". But he said he will marry me on Saturday. But his friend asked me if I have sex with my boyfriend and I said, "Yes!" And he said, "Very good, you are doing the right thing".

A good girl

She remembers the lessons that she learnt in church about pre-marital sex.

But I was going to church. They said I must not have sex before marriage but I must love my boyfriend. The church said I must get married and have a wedding. They said

I must be a good girl, who is clever. But my boyfriend's friend says I must have sex with my boyfriend, because he is my boyfriend, so I am having sex.

Nyarai recounts that she is standing on a promise of marriage from Mavhu.

He said he will marry me in his church, the Anglican Church. We will have wedding and I will wear white and he will wear a black jacket. I will invite you and I will also invite Mrs Chido and Mrs Tafi and my aunt. My father will not be there because he is working and he never comes to see me. But it doesn't matter; I will just marry Mavhu because I love him.

She further outlines her marriage plans.

*He said he is going to pay **roora** (bride price) for me then we have a wedding. I was sick when I came here, so now I am ok! I want to marry and to get out of here. Today I saw him and he said, "What did you say about marrying me?" I said, "Mavhu, that is your story".*

But what is a condom?

Nyarai became curious when she heard her female house matrons talking about sex and a condom.

The matrons were saying sex and a condom. But I don't have a condom. My boyfriend doesn't have a condom. I don't know what a condom looks like. I asked my boyfriend and he said he doesn't know what to do with a condom, but we have sex in the chicken run. He kisses me and he gives me a hug and I am happy. He touches my body. But we have sex. We have sex on Monday at the chicken run and we have sex.

Nyarai proffers explicit details of some of the sexual encounters that she shares with her boyfriend.

My boyfriend has a penis and I have a penis too. He was touching me, he took off my underwear and he put his penis. I thought I was going to be pregnant. I was to have four babies. My boyfriend said he wants 14 babies. We have sex for four days every

week. We have sex at the chicken run at the gardens. He touches my breasts. He has a big penis but I don't touch it. Even today he calls me in the afternoon to have sex.

Nyarai's boyfriend is not allowed to visit the female hostels and neither is Nyarai allowed to visit the male hostels. However, they have worked out an arrangement whereby Nyarai meets with her boyfriend during gardening time to have sex in the chicken run at 4 o'clock in the afternoon on most days of the week. *"We do gardening at 4, and that is the time we have sex in the chicken run. I thought I was going to be pregnant."*

This place is boring

Nyarai expressed her frustrations about an institutional lifestyle.

The matron makes me do a lot of work, cleaning and washing and she throws buckets on the floor when she is shouting to say you have not done this. The people here they shout so this place is boring. I will just stick to my boyfriend, so that when we get married I will go with him to their village to live with his mother, because this place is boring. I think life with him in their village and with his people will be better for me.

Nyarai therefore perceives marriage as a possible escape route from a frustrating institutional lifestyle.

Epilogue

Nyarai's narrative is that of a woman who is in love and who values the expression of her sexuality, albeit not having been afforded appropriate sexuality vocabulary and education. Her narrative shows that in spite of the restrictions that are placed on her by the institution, she is having unprotected hurried sex with her boyfriend in improper places such as the chicken run. Indoctrinated with heterosexual marriage values, Nyarai is hoping to use marriage to escape the restrictive practices at the institution. Although she would have wanted her father to attend her wedding she realises that her father is absent. However, she resolves to live with her boyfriend's family after the marriage, thereby indicating her appreciation of relationships of kinship in the traditional framing of marriage. Nyarai's narrative depicts the intersection of disability, gender, culture, class and religion in framing her experiences of sexuality. I present the narrative of Danai who has albinism, below.

5.3 Danai's story of naivety and conscious strategy

When I first met Danai in 2014, it was in a cafeteria in the city centre and she was clad in dark green trousers and a white shirt. Danai carried the exuberance of a confident and happy woman. She gave me a warm welcome and agreed to meet with me on a different day for the interview. On all interview occasions, we sat in one of the offices of a city block, as Danai calmly and unhurriedly recounted her life story with a positive attitude. I present Danai's story below.

My father's clan

Danai is a 37-year-old woman who was born in a family of five. She was raised by both her parents who at the time were living in one of the high density suburbs of Harare. She is the only person with albinism in her father's family lineage. *"I am the only albino in the entire clan of my father"*. Her birth did not make life easy for her mother, who was accused by her father of breaking traditional taboos when she was pregnant. *"My father said my mother was eating some forbidden wild fruits and some crabs when she was pregnant, that is why I got albinism"*. However, Danai's brother argued that Danai's albinism was caused by witchcraft, because some members of their extended family were known to be practicing witchcraft.

Avenging spirit

In seeking answers to the reasons why albinism had come upon Danai, her parents sought the divinations of traditional healers.

*One traditional healer said my albinism was caused by the **ngozi** (avenging spirit) of a woman who came from South Africa to live in Zimbabwe with my great grandfather. He had not paid **roora** (bride price) for her, so he broke an important African custom...*

The traditional healer advised Danai's family to appease the avenging spirit so that Danai would be cured of albinism.

*He said they must pay **roora** (bride price) for the dead woman but they don't know her people in South Africa. The healer said they should give **mukadzi wengozi** (a wife for*

the avenging spirit), *a virgin girl to the woman's family, to appease her angry spirit which caused my albinism.*

By the time the traditional healer had seen what was happening with the **ngozi** (avenging spirit), there were no virgin girls left in Danai's family. Being only two sisters in her immediate family, her other sister had since been married. Danai herself was deemed inappropriate for the purpose because of the nature of her impairment. However, her father was sent by the elders of the village to Mozambique to scout for a virgin girl that the family could marry and send to South Africa **semukadzi wengozi** (as a wife for the avenging spirit), so that the avenging spirit of the deceased woman could be put to rest.

The poor families in Mozambique can take money and send the daughter away. So my father found a virgin girl in Mozambique and paid bride price for her. But he left the girl in Mozambique because he is waiting for the healer to reveal the village of the dead woman so that they can take the girl to South Africa.

Starting school

Whilst her family was trying to work out a traditional treatment plan for Danai she started school (Grade 1) at a city primary school at the age of six. However, her family could not afford to provide her with the impairment aids that she required.

I needed spectacles for my poor eyesight and sunscreen for my skin but my family was poor so I didn't have. I developed a cancer lump on the upper lip and then I had an operation to remove it. After that I went to boarding school for high school when I was 13 years old.

Adolescence

Danai struggled to manage her menstrual periods which began at the age of 13 during a school holiday. When she told her mother that she had started menstruating her mother advised her to keep the development to herself.

She said it's a top secret, don't tell anyone, just take a traditional cloth and wrap it around yourself. So I did that and I started to think that such was the "job" of a

traditional cloth. My mother did not say anything else about menstruation, she just kept quiet.

Danai faced some challenges when she went back to boarding school because she was expected to wear a school uniform and not a traditional cloth during menstruation. *“But the girls in school talked about buying cotton wool. So when my brother gave me money, I bought cotton wool and underpants and I was ok!”*

Danai struggled through school until she sat for her ordinary level school leaving exams at the age of 16. Due to poor eyesight, she failed all her exams and she left boarding school to go and live with her brother in the city. *“It was hard for me to pass because I was not seeing properly, so I failed everything and I went back to my brother’s house.”*

Rape

At the age of 17 Danai started dating Munopa, a non-disabled man who is 13 years older than her and a man who later raped her.

He was a Civil Engineer and he is older than me. I met him on the road then he said let’s go this way. I didn’t realise that he was taking me to the maize field for sex until we got there. It was not affection, it was rape; he forced me and I got pregnant. I got very scared when I saw his penis growing big because of an erection. I was so frightened because I didn’t know that people have things on their bodies that grow just like that. I was very young.

When Danai realised that she was pregnant, she informed Munopa who became antagonistic towards her. *“He shouted at me and I was afraid of him so I told my male friend Kuda about the whole story, but Kuda could not help me in any way.”* When Danai’s pregnancy started to show and her father heard that she was pregnant he summoned her to the rural village to which her parents had moved. *“My father said I must go to the village and deliver my baby quietly in my parents’ care. My father loves me but my mother never really liked me from the start because I am albino.”* Her mother was indifferent about Danai’s pregnancy, so she did not educate Danai about issues of reproduction.

...when I went to deliver my first baby I didn't know how the baby was going to come out of my body. I was thinking that maybe a hole will open on my stomach and the baby will come out through that hole. I just didn't know a lot of things, because my mother was not telling me...

After delivering her baby boy at a rural clinic and nursing the baby for one year in the village, Danai's father sent her back to the city so that she could live with her sister as well as go back to school. *"But now my sister's husband wanted to have sex with me. I said, 'No!' But my sister still kicked me out of her house because she saw that her husband was liking me."*

"True" sex

When she left her sister's house Danai went back to her brother's residence. *"At that time I was 20 years old and my brother decided to send me for a full year dressmaking course at rehab."* Remembering that she had failed her ordinary level school leaving certificate examinations she also joined a class that was preparing for such examinations. *"I was working hard because I wanted to pass and to look after my son. I was doing dressmaking during the day and the other subjects in the evening. My parents helped me to look after the child."*

Danai noted that a lot of disabled women at the rehabilitation centre were involved in intimate partner relationships with both non-disabled men and disabled men. *"Some women had disabled and able-bodied boyfriends, but I was finding it hard because I was traumatised by the rape that had happened to me when I was 17."* She decided to seek wise counsel from a male Counsellor who was resident at the centre.

Because he was the Counsellor at the rehab, I told him about how I was raped. I was thinking that he was going to help me with counselling. But the counsellor said, "The man who raped you did not show you love, you did not experience the sweetness of sex, so now I want to show you true sex so that you can enjoy it properly". I ran away.

As time went on Danai discovered that the Counsellor was also pursuing other disabled women at the rehabilitation centre for sex.

We were poor so we could not afford to buy sewing machines to use after our dressmaking course. So the Counsellor was promising to buy us a sewing machine in exchange for sex. I said, "No! I can't do it, I can't earn a living with sex". Anyway he became too fat and he died, but I think its AIDS because he was promiscuous. I felt sorry for his wife.

Danai remembers other incidences of sexual abuse that she witnessed at the rehabilitation centre.

Men who come there for rehabilitation want to have sex with disabled women. A lot of the women are impregnated. The men they don't use condoms, so disabled women also get STIs and HIV. I saw it with my own eyes.

Danai successfully completed her dressmaking course and five ordinary level school leaving subjects before she left the rehabilitation centre, heading back to her brother's house.

Danai's lifestyle took a different turn when her brother got married. *"My brother loves me, but his wife came and gave me one cup and plate and said this is for you Danai. She was afraid that if we share things, I would give her albinism."* Danai continued to befriend Kuda, her male friend who lived in the neighbourhood. However, some non-disabled women who lived in that community stigmatised her due to the friendship. *"These girls who call themselves 'normal' and Black were making fun of me saying arikutaura nemurungudunhu* (he is talking to a quasi-white person). *They made me feel cheap."*

Becoming a teacher and a mother

Danai got tired of loitering aimlessly around the streets of the high density suburb and she decided to apply for a place to train as a primary school teacher. At age 26, she enrolled at a local teacher training college on the strength of her ordinary level school leaving certificate. Whilst she was on the programme, Danai and Kuda agreed to change their relationship from that of ordinary friendship to an intimate love relationship. *"Kuda was unemployed because his father died in the war of the liberation struggle and his mother ran off with another man so he did not get good schooling."* Danai's family despised Kuda for his unfortunate background and poverty but Danai decided to nurture her intimate relationship with Kuda.

I decided to love him, because I saw that those who were not poor would not love me. My family hated him; they said he was not educated and he wanted to take advantage of me, but I was ok with the relationship. Kuda's family also did not like me because of my albinism.

Danai and Kuda agreed to have a baby. *"At that time I was 28 years old. He told his family that he was responsible for my pregnancy and he wanted to marry me".* Kuda's family opposed his plan. *"His family said we cannot have such a **muroora** (daughter-in-law), she is albino."* However, Danai eloped to Kuda's place of residence where he was living with his grandmother at the time, but the grandmother refused to accept her. *"She said, 'Here at my house, I only have a place for my grandson but not for you'. I knew that she didn't like me because I am disabled."*

Danai and Kuda were offered accommodation at Kuda's uncle's house. *"But his father's younger brother who is very poor took us in and we stayed with them for a few months."* Danai started to help the uncle's family to meet their living expenses with her student teacher allowance. *"With my allowance, I bought them groceries and paid for the other needs of that poor family that had zero income before my arrival."* However, as time went on, Danai and Kuda were able to secure their own room to rent in the neighbourhood and they moved to a place of their own. *"Kuda was still not working, so I was meeting all our expenses".* Danai gave birth to a baby girl and eight years later she gave birth to another daughter.

I was happy to deliver a baby girl with normal black skin. After eight years and when I was aged 36, I gave birth to another baby girl with black skin. So Kuda's family could not complain about the children because they are not disabled like me. Now I have three children, first born is 17, the second is nine and the third is one year old. My first child was rape but my last 2 were planned. We all live together with my boyfriend. I don't know what happened to the father of my first son. He never took care of the child.

Danai enrolled her daughter at a different school to the one where she teaches.

I decided to enrol my daughter at another primary school and not at the one where I am teaching because I know other children will be laughing at her and saying her

*mother is **musope** (albino) and such talk would negatively affect her. It's not easy because issues of disability are associated with witchcraft and evil spirits.*

Unpaid “roora” (bride price)

Danai is not happy with the fact that Kuda has not made an effort to pay **roora** for her.

*He has not paid **roora** for me but we have been living together for 10 years. I feel that for the sake of my parents he should pay **roora**, so that my parents can feel that they have a son-in-law, not that I am living with a boyfriend.*

Danai lives with guilt because at the back of her mind she knows that her living arrangement is not customarily acceptable. *“Traditionally it's not right. I am just doing it, but it doesn't make me happy. He cannot interact with my family and my brothers properly because he has not paid **roora** for me.”* Upon questioning Kuda about the reasons why he is not marrying her, Danai was unable to obtain a satisfactory answer. *“I asked him why he doesn't want to marry me and he has not given me an answer. But I just say at least I have a ‘husband’ to live with.”* Danai decided not to pursue the issue of **roora** any further, but to strategically maintain the relationship for purposes of benefiting from Kuda's love and affection. *“Sometimes I get sick but he sticks around. At one time I had a very big wound on my thigh and I thought that he was going to run away, but he didn't.”*

She gives explicit details of her experiences of sexuality with Kuda.

I don't like kissing, so we don't kiss, but I like it when he touches my body and the penetrative sex I like, but not all the time. I used to wipe his penis after sex but now I leave him to do it himself, because I saw that he does not want to marry me.

Things of the heart

Danai sums up the lessons that she learnt about her experiences of sexuality.

Even if I am disabled, I need someone to love me, and to share my things of the heart with. Even those who cannot talk they need someone to love them. I saw it at the rehab centre; people with different disabilities were falling in love.

Hats and sunscreen

In future, Danai intends to work in close partnership with the Albino Association of Zimbabwe to raise funding for the procurement of impairment aids for people who have albinism in the country.

I appreciate the few boxes of sunscreen that are offered at once-off events by local companies but I would like to urge such companies to consider long-term donations. What happens to the albinos when that one tube of sunscreen is finished? They begin to suffer again. So life is not easy, especially for poor people who cannot afford to buy hats and sunscreen. They develop skin cancer and they die. I will work with the Albino association.

The above narrative indicates that Danai is devoted to working towards reducing the suffering of people who have albinism in Zimbabwe, by engaging relevant stakeholders. She therefore does not regard herself as a downright victim of albinism but she claims her agency and she seeks to help others with whom she shares a common impairment.

Epilogue

Danai's narrative depicts a disabled woman who rises from a level of naivety to a point where she begins to consciously strategise until she establishes herself as a primary school teacher. However, she challenges the myth of asexuality by expressing her sexuality in diverse ways. Danai acquires a long-term intimate partner relationship with a man, albeit a poor man who is economically dependent on her. The narrative indicates that Danai is yearning for heterosexual marriage in a context where she believes she would earn respectability if *roora* (the bride price) is paid for her by her boyfriend. Danai acknowledges the oppression that is characteristic of her experiences of sexuality but she also focuses her narrative on the ways in which she negotiates the difficulties she encounters and the choices she makes in relation to her sexuality. Her narrative depicts the intersection of disability, gender, culture, poverty and class in framing her experiences of sexuality within a heterosexual context. I present the narrative of Chipso, who has a spinal cord induced physical impairment, below.

5.4 Chipo's story of rejection and resilience

It was in 2014 and at the start of my research field work when I found out about the local DPO that Chipo works for, on the internet. I subsequently set off on my expedition of trying to meet with her so that she could help me to identify a disabled woman that I could interview. When I got to her office she was not there, hence I decided to sit under the shade of a huge tree which stood in the office car park, whilst reading one of the local newspaper publications of that day as I waited for her arrival. About half an hour later, Chipo arrived and I immediately noted that she is a huge, beautiful, bubbly and confident woman who has a physical impairment. I stuck to my plan and I asked her to refer me to a disabled woman that I could interview. She responded boldly by saying, *"How can I refer you to a disabled woman when I have a disability myself? I have never spoken about my sexuality so I can only pass you on to another woman when you are done with me."* I interviewed Chipo at her house on different days when she would send her entire family to daylong Christian church services within the neighbourhood of her area of residence. On all occasions, she sat in her wheelchair as she calmly recounted her life story.

Rape at age 17

Chipo is a 54-year-old woman who has a spinal cord injury induced physical impairment and she uses a wheelchair. *"I am 54 years old, I was born and raised in a family of my father's three wives and 24 children and I attended a boarding school in our village for both primary and high school."* Whilst she was in high school Chipo started menstruating and adolescence dating. *"I started menstruating in school at age 13 and I didn't have any problems because I was taught about it by **maiguru** (uncle's wife). I had my first boyfriend when I was in school at the age of 14."*

Chipo's relationship with her first boyfriend ended when she was raped by a different man at the age of 17, whilst visiting her brother in the city during a school holiday.

My sister-in law sent me to collect an empty bottle from their neighbour's house. When I got there, the man who lived alone locked the door, tripped me to the ground and raped me and broke my virginity. I informed my brother's wife that I had been raped and she said, "Don't tell anyone else about the rape, just go back to school".

When Chipo was back in boarding school she discovered that she had fallen pregnant as a result of the rape. However, due to policy restrictions at the school, she was unable to return to her brother's house during the school term to advise her sister-in-law about the development. She waited until the school holiday to announce the news to her brother's wife. Upon being told about the pregnancy, her sister-in-law appeared undisturbed by the news. *"She said, 'Don't worry, the man will marry you' and the rapist said, 'No problem, I will marry the girl'."*

True to her sister-in-law's proclamation, the rapist professed great love for Chipo and offered to marry her. At the age of 18, her family made arrangements for her to drop out of school and to marry the rapist. *"I married this man, 10 years older than me, not because I loved him, but because of rape."* However, what followed thereafter was a blissful marriage, characterised by love and affection. *"He did not shout at me, he was a nice man. I felt he was feeling too much love for me. Within nine years I had given birth to five children."*

I won't walk again

As their family continued to grow Chipo saw the need to assist her husband to fend for the family. At the age of 38, she teamed up with her friend and she became an informal cross-border trader, constantly travelling between Zimbabwe and South Africa.

I was selling African clothing in Cape Town, South Africa and buying household products in South Africa to sell back home in Zimbabwe. It was during one of my trips that I was involved in a car accident. I was travelling with my friend when we asked for transport from a man who offered to drop us off at our place of temporary habitation in Wellington, near Cape Town. The truck overturned, resulting in my friend and the man who was driving the truck dying on the spot.

Chipo was admitted to a hospital in Cape Town. *"I was in coma for three weeks and I could not talk but I came out of coma and the doctor explained to me that I had suffered a spinal cord injury and I was not going to be able to walk again."* Chipo expected her loving husband to be the first person to visit her in hospital. However, it was her brother who got to the hospital first, after travelling by bus from Zimbabwe to Cape Town (approximately 2 500kms). Her husband only visited her after she had spent about three months in hospital. However, it was such a visit that marked a turning point in their marriage.

...he asked me a stupid question. Imagine I have a major operation; I'm coming out of theatre and eh! the only thing he asked me was eh! "Are you able to go to the toilet?" How can a man ask such a silly question? I said going to the toilet is not the reason why I am in hospital. I am in hospital because I am fighting for my survival. Then the nurse asked my husband to leave my room. I think she saw that he was upsetting me.

"Death" of sexuality

Chipo appreciated the fact that she was given a brand new wheelchair by the hospital, as she left Cape Town heading back home to Zimbabwe, after staying in hospital for about four months.

I was grateful that the hospital gave me a new wheelchair, but when I got home I started to have many problems. The man I trusted had changed. He no longer loved me because I was now disabled. Sexual activity between us began to die. He tried to have sex with me once a month, then we moved to once in six months and then to once a year, then we stopped completely.

Chipo realised that she had lost the love and affection of a husband with whom she had once enjoyed a blissful marriage for a period of two decades. *"My husband started to see me as dirt. He would not touch, hug or kiss me as before. I was now feeling very lonely. Disability can surely disturb sexuality in marriage."*

Chipo further illuminates her husband's insensitivity towards her.

He would take a blanket and sleep on the floor in the dining room to avoid contact with me during night time. He only returned to the bedroom when our children had questioned him as to why he was now sleeping in the dining room. He then would come to bed and wrap himself up with a separate blanket to avoid contact with me. Even the children knew that their father loved me, but when I became disabled my life of sexuality with him died.

About two months after arriving home from the hospital in Cape Town, Chipo's father brought her younger sister (a widowed mother of two) from their rural village and offered her to Chipo's husband as a second wife. *"My father said my husband paid **roora** (bride price)*

for me in full so it's unfair for him to live with a disabled wife. He said my husband would not enjoy his conjugal rights with me because of disability." Chipo observed that her father was bent on securing her husband's conjugal rights but not hers. *"These men, whether it's your husband or your father, they think the same; they care about their own sex, not of women."*

Whilst she was disputing the polygamous arrangement that her father was structuring for her, Chipo's husband was excited about the plan. *"My husband began to make sexual advances towards my sister."* Her father had not asked for Chipo's opinion prior to taking the decision to offer her sister as second wife to her husband.

He thinks it's good to decide everything for a disabled woman, because a man should not suffer because his wife is disabled when he can be loved by an able-bodied woman. No one has time to ask how you feel. They are quick to ask your husband to find another wife or they get one for him.

In opposing her father's plan, Chipo was concerned about the possibility of HIV infection.

I was thinking that if my sister is infected with HIV, then she would transmit the virus to me through my husband if he decides to have sex with me at some point. I suspected that my sister was HIV positive, because her husband had died of AIDS. I said, "Father, but there is HIV, what if my sister is HIV positive?" When I spoke about HIV I was right because my sister was HIV positive so she became sick with AIDS and she died.

Following the death of Chipo's sister, her husband began to pursue Chipo's brother's daughter for sex. *"The girl was 15 years old and she was living with us. My husband started to have sex with her. He was supported by his relatives who said that Shona culture allows him to make my niece a wife."* When Chipo discovered that her husband was being sexually intimate with her niece, she informed her own mother who responded by taking the girl back to her parents in the village. Her husband was infuriated by such a move and he escalated his level of insensitivity towards Chipo. *"He was cross that I refused for him to take my sister or my brother's daughter to make them his wives; he made life hard for me."*

Not even a penny

Chipo's husband withdrew all the material support that he used to give to her before she acquired a physical impairment. *"He used to surrender his whole salary to me so that I could use the money to run the home, but when I got disabled he stopped."* With discontinued financial support from her husband, life became very hard for Chipo because at that time she was unemployed. *"I was just a housewife in a wheelchair, I was not working. Even up to now my husband does not give me a single penny. I think he spends his money with 'small houses' (mistresses)."*

Chipo secured formal employment as a Counsellor for disabled people at a local Disabled People Organisation (DPO). *"When I was 44 years old, I got a job for counselling disabled people. Thank God that I now have this job. I meet all my living expenses with my own money."* When her husband realised that Chipo had secured employment, he withdrew all the material support that he was giving to their children, leaving all such responsibility to be shouldered by Chipo. *"It's like by getting a disability I committed a crime. So with my salary I pay for everything; I support the whole family including paying fees for my 28-year-old daughter who is still in University."*

A man is a man

The relatives of Chipo's husband stigmatise her for her impairment.

*In African culture, a good daughter-in-law is the one who runs around doing housework, so they say I am a useless woman because I am disabled. They say, "Why are you punishing your husband?" Ask him to get another wife, **asi hauzive kuti muchivanhu chedu murume murume** (do you not know that in our African culture a man is a man).*

Her husband's relatives do not realise that Chipo is the brains behind the running of the home.

I provide the funds for running the home and I bark orders from that wheelchair to get the home organised. I tell my children and my grandchild what to do and they love and respect me. But the first thing that my husband's relatives say when they visit my house at any time of the day is they ask my children to prepare for me to go to sleep

because they think a wheelchair means I am ill; they think the only human being in the house is the man.

Culture places limitations on the manner in which Chipo responds to her husband's stigmatising attitudes.

They come and sit in my house and eat the food that I have bought with my own money from my work as a Counsellor, but they still find me unfit to sit in the same room with them and participate in the discussions they have with my husband. They think my brains are dead because I am in a wheelchair. So I just look at them and listen, because culture does not allow a wife to challenge her husband's relatives, so I just leave them with their ignorance.

Seeking new relationship

Frustrated by her husband's continued physical and emotional detachment, coupled with the stigmatising attitudes of her husband's relatives, Chipo decided to get a boyfriend with whom she could have a sexual relationship. *"I got tired of my cold marriage and my husband's horrible relatives, so I just decided to quietly get a boyfriend."* Chipo argued that instead of living a miserable life, in a context where she felt she was trapped in a world of her own, she decided to develop her own sexuality survival skills. *"Disability brought misery in my sexuality when my husband rejected me, so I saw that getting a boyfriend on the side was the only way that I could deal with my sexual life."*

Chipo is now a happier woman because she believes she has found a man who loves her.

You see this is a man who has loved me after disability. Compared to my husband who raped, loved and married me when I was young, beautiful and able-bodied and now with disability he finds me disgusting. I am now happier with my boyfriend.

Chipo's boyfriend is a top notch professional in his field of work and he is also a legally married man who is related to her husband. *"We do everything, he takes off all my clothes and he takes off all his clothes. We do tongue kissing, he sucks my breasts one after the other and he kisses my whole body and my vagina also."* On their regular romantic outings they

normally spend about four hours together. *“After doing all this kissing and touching, we end it all by having penetrative sex. We spend about four hours together doing all these things.”*

Whilst Chipo has remained married to her husband on paper (marriage certificate), they are emotionally detached. *“With my husband we are still ‘till death do us part’, but there is no more love between us or sharing sexuality.”* She believes that culture is contributing towards stopping her husband from instituting divorce proceedings against her or from simply moving out of their matrimonial home.

*My husband comes from **Bikita**, an area where devoted followers of Shona culture come from. Such people are afraid of ancestors so that is why he still lives with me. He fears that if he leaves the ancestors will give him misfortunes. But, we have no connection and to me he is just like a picture on the wall.*

Chipo theoretically sticks to her husband whilst at the same time she addresses her sexuality with her boyfriend.

I just say for culture let me keep on pretending, so that people continue to just call me “Mrs”, because that is what culture respects. I think that if I remove this blanket of pretending about my marriage, what will people say? African culture teaches us to stick to a husband as if he is a God. Even me I am now empowered by the women’s movement, but when it comes to culture, I think that if I divorce it will bring shame to my family, my children and my husband’s family, so I just say let me keep on pretending. Culture makes me weak.

To the outside world, Chipo and her husband are a perfect couple with a successful marriage which is credited with a duration of more than three decades (36 years). She is admired as an upright woman who has managed to maintain her marriage and raised five children that were fathered by the same man. *“People just don’t know that I am surviving because I am addressing my sexuality with my boyfriend and he gives me the courage to carry on. I don’t have a life of sexuality with my husband.”* Chipo’s husband is respected as a man who has not deserted his wife who became impaired during the subsistence of their marriage.

*But the truth is he left me a long time ago, people just don't know. In fact, we have been apart for the past 16 years, because disability came when I was 38, now I am 54. But me, my husband and the kids we know the truth, that there is no marriage. Even the other women who are in the women's movement they say **mai mwana zvinonyadzisa kurambana** (mother it is shameful to divorce).*

Chipo has now reached the age of menopause, so she is unable to naturally have any more children.

If I was still at that age of child bearing, I would have wanted to have many children with my boyfriend, because I love him so much. But even if I am menopause and 54, there is still a young girl inside of me who is yearning for love.

My vagina

Chipo uses vaginal products to enhance eroticism in her sexual relations with her boyfriend and she also esteems her elongated labia.

Vinegar tightens my vagina to make sex nicer. It also reduces the bad smell of the vagina. A woman sold me traditional herbs that caused me blisters so now I just stick to vinegar. When we are together, my boyfriend goes straight for my pulled labia. I am happy that I pulled, I make him happy.

Chipo appreciates the fact that her boyfriend considers her to be a brainy woman.

My boyfriend sees me as a "normal" person; he does not associate my wheelchair with stupidity. He even asks for advice from me and he tells me about the very deep issues of his life. We would like to get married but we can't; I am legally married and he is also legally married and he is also my husband's relative.

HIV/AIDS

Chipo suspects that her husband could now be infected with HIV, considering that he has been recovering from Tuberculosis (TB). *"He is now very thin, he has been suffering from TB, I think its HIV, because he has been promiscuous."* In addition, Chipo's husband has been hiding antiretroviral drugs in an upper shelf of their bedroom wardrobe. *"Had it not*

been for my 28-year-old daughter who drew my attention to such medications, I would not have noticed them. Because of the nature of my disability, I can't reach such heights."

Through her job as a Counsellor, Chipo observed that a huge number of disabled women are dying of HIV related ailments. *"Disabled women are quick to jump into bed with any man who comes their way, on the belief that a man who comes to have sex with them is doing them a favour."* She noted that some disabled women get misleading counselling from churches and family members. *"They are told to be submissive to their husbands at all times according to the Bible and according to African culture; they just follow such advice and have sex without questioning."*

I will keep them both; my boyfriend and my husband

Chipo sums up the lessons that she has learnt about her experiences of sexuality thus far.

If you tell anyone about your marital problems, they say it is your duty as a wife to understand your husband. It's this African culture, I have to make sure I please my husband sexually and everything. How can I do it without his support? They say, "Try harder, push harder", but what is it really that I should try harder and push harder, they don't say. For my future life, I intend to keep both my boyfriend and my husband.

In the above quote Chipo summarises the challenges that ethnicity places upon her experiences of sexuality and her future relational intentions.

Epilogue

Chipo's story is a story of rejection and resilience in a context where the acquisition of impairment in the course of her marriage damaged her experiences of sexuality as her husband and his family, as well as Chipo's family members, began to foreground her disability at the express exclusion of all her other social life attributes. However, Chipo resists the disability and sexuality stereotypes that society imposes on her and she claims her agency by securing an extra-marital relationship for herself as well as employment with a local DPO. Chipo demonstrates an awareness of the oppression that is characteristic of her experiences of sexuality, but she highlights the various turning points in her life, where she negotiates power relations and the difficulties she confronts. Chipo's narrative indicates the intersection of disability, gender and culture in framing her experiences of sexuality.

In the next chapter I present the themes that arose from the analysis of all the 16 narratives that make up the entire data of this study.

CHAPTER SIX

ANALYSIS OF NARRATIVES

Introduction

In this chapter, I present the themes that emerged from a cross case-analysis of the 16 narratives that represent the entire data set of this study. My analysis approach began at the first or manifest level in the previous chapter, where I foregrounded the biographic narratives of four participants. However, at this second level, I employed the analysis of narratives approach to generate themes from the four stories which I subjected to narrative analysis in the previous chapter, as well as from the other 12 narratives that I did not include in the preceding chapter, but which I presented in synopsis form in Appendix 18. As noted in Chapter 4, analysis of narratives produces distinctive themes, whereas narrative analysis, as employed in Chapter 5, produces whole life stories. Whilst the analysis of narratives employs paradigmatic analysis which produces themes as is common in other qualitative research studies, what differentiates it from other approaches is that it takes stories as its primary data for analysis (Polkinghorne, 1995). As such, the themes that are presented in this chapter arise from the stories that participants told about their experiences of sexuality.

Although I make reference to the narratives that I have presented in the previous chapter, I do not repeat quotes that I have already presented in that chapter. However, I draw direct quotes from the other 12 narratives that I have not presented in Chapter 5. In addition, I provide linking commentaries to both my references to quotes and the direct quotes in an effort to illustrate features that seek to answer the research question. I take it that, in the previous chapter, the direct quotes of the narratives of participants “spoke” for themselves; hence at this second level of analysis, I seek to articulate the meaning of the data. Such meaning making marks the beginning of the process of cross-case theorisation which is aimed at, among other things, contributing towards the development of indigenous theoretical formulations of disability and sexuality that are rooted in the African context. As I previously indicated, my three tier approach to data analysis ends in the following chapter, where I present a deeper layer of analysis which is intertwined with the discussion of findings.

I borrow practice from a study carried out by Thomas (2001) on disabled women's healthcare encounters in the UK, and state that the attention that I may pay to "bad" experiences in relevant instances of the thematic discussions is not meant to paint a negative picture of the experiences of sexuality of participants, but it is meant to enhance an understanding of such experiences, with the aim of instigating action that is directed at reducing or eliminating oppressive practices. As I mentioned in Chapter 2, it is my hope that my attempt to exhume the silent voice of the participants opens up such voices to yield strength for the research subjects, as well as open up ears in the research arena. In addition, by predominantly illuminating the identity markers of disability, sexuality, culture and gender in the thematic findings, I do not mean to say that those are the only four social life attributes that intersect to frame the experiences of sexuality of participants. As such, I weave in additional social life attributes as they emerge in the discussion of the themes and sub-themes.

Four main themes emerge at the point where the predominant identity markers of disability, culture, gender and sexuality intersect. The themes are: (1) dynamic engagement in intimate partner relationships; (2) gender based violence (GBV); (3) matrimonial relationships; and (4) silences surrounding issues of sexuality. Whilst each of the themes is addressing a different subject, the themes are embedded with some fascinating zones of interconnectedness. The themes reveal the complex intersection of disability, sexuality, gender, and culture in a patriarchal context where participants are constantly negotiating power relations as they dynamically engage in intimate partner relationships which include matrimonial relationships. Such an intersection is a key driver of the vulnerability of disabled women to GBV which is characterised by inequitable, unsafe and coercive sexual practices that increase their vulnerability to HIV infection in a context where the silences that surround issues of sexuality are detrimental to the well-being of disabled women, including in matrimonial relationships. However, there is evidence of various instances in which participants claim their agency, as they seek to assert and express their sexuality in a setting where they are generally regarded as asexual beings.

Theme 1: Dynamic engagement in intimate partner relationships

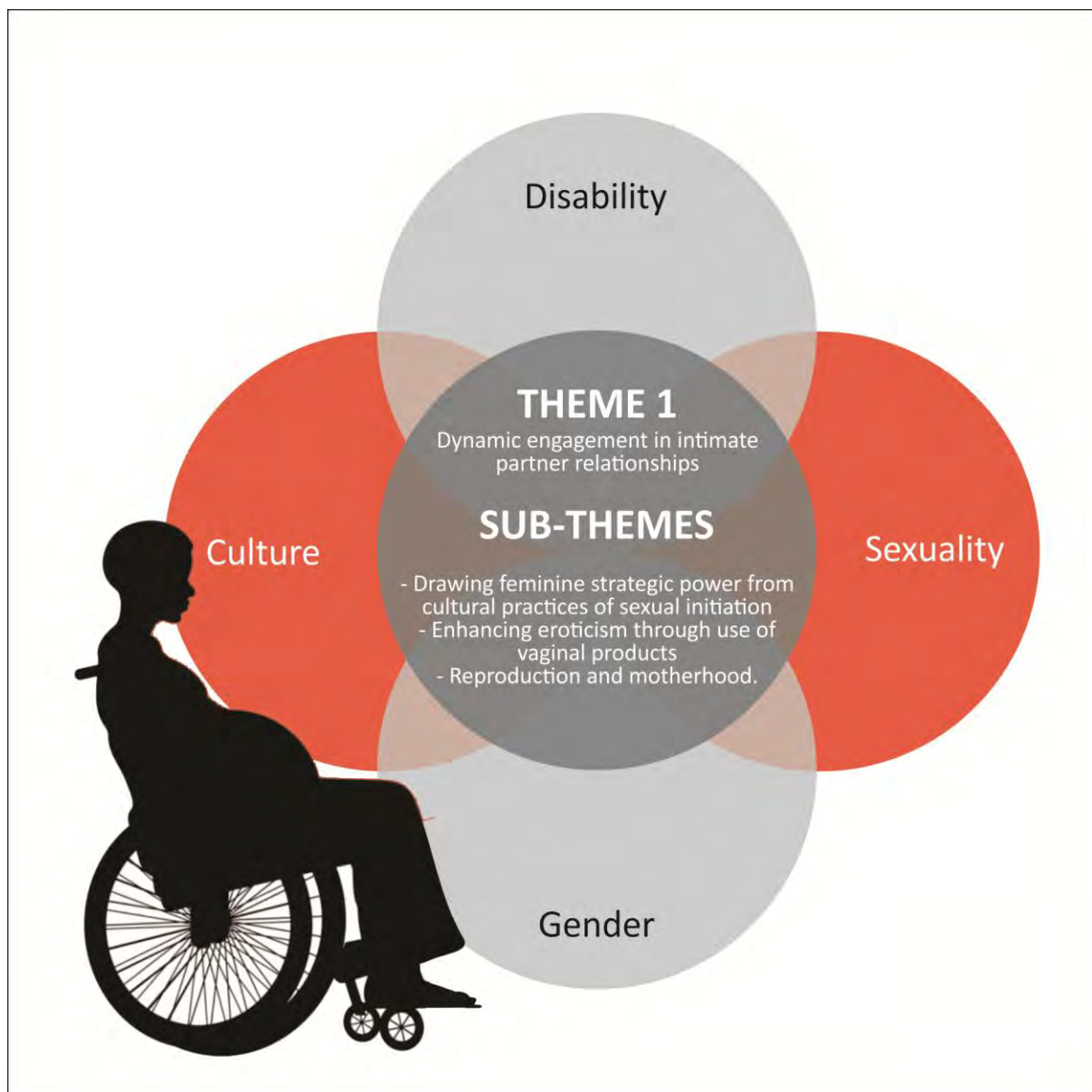


Figure 3: Dynamic engagement in intimate partner relationships

Figure 3 above, illustrates that the theme of the dynamic engagement of disabled women in intimate partner relationships is embedded with the sub-themes of: a) drawing feminine strategic power from cultural practices of sexual initiation; b) enhancing eroticism through vaginal products; and c) reproduction and motherhood. The theme and its integral sub-themes illuminate the intersectional nature of the experiences of sexuality of participants. All disabled women who participated in this study are sexually active and they position themselves as sexual beings in a myriad of ways. For example, Nyasha, who is visually impaired, says: *“I am close to menopause so I think it’s not safe to have a child but I have a boyfriend, I now just want a husband to share my life with.”* All participants provided explicit

details about their range of sexual experiences and preferences, as exemplified by the narrative of Tatenda who has an intellectual impairment:

...I don't see myself ever sucking a man's penis. I think it's disgusting. My ex-husband used to ask me to suck his penis but I said No! It's a No! No! I have no time to do such things...Oh! No! I like penetrative sex and that's all, and that's all I will do when I get married.

Referring to her ex-husband, Saru, who is Deaf, says:

We are both Deaf but when I wanted romance, he could not do it. He just wanted sex. But you know I didn't want sex every day. I wanted other things like touching, or kissing. Oh! But the kissing was horrible because he was a chain smoker who was smelling tobacco all the time, so I just had to forget about kissing. Anyway we divorced and now I have a non-disabled boyfriend.

As noted in Chapter 1, sexuality has historically been regarded as male sexuality which is characterised by masculine sexual pursuits (Andrews & Studd, 2005; Makinwa-Adebusoye & Tiemoko, 2007). However, it is apparent that all participants construct their own understanding of what it means to be sexual and they assert that their sexuality is separate and distinct from the sexuality of men. In addition, and as noted in Chapter 3, the traditional perspective of sexuality in most African communities hinges on penis/vagina coitus (Makinwa-Adebusoye & Tiemoko, 2007). Whilst some participants may prefer such a mode of experiencing their sexuality as exemplified by Tatenda's narrative above, others resent penetrative sex and may wish to explore different ways of addressing their sexuality, as highlighted in Saru's narrative above. Whichever way, the manner in which participants elucidate their sexual preferences provides evidence that disabled women are not asexual beings as generally alluded by society, but they construct their own understanding of what it means to be sexual, thereby asserting their sexuality in ways that challenge the dominant, restrictive and ableist constructions of sexuality.

The narratives of participants challenge the social model of disability for focusing on disability and environmental barriers and discouraging discrimination of disabled people on the grounds of impairment, whilst at the same time the model neglects issues of sexuality. As

noted in Chapter 2, by focusing on disability and ignoring other identity markers such as gender, culture and sexuality, the social model privileges disability at the expense of other social life attributes. However, the narratives of participants demonstrate that a disabled woman's life world is not wholly framed by a single social life attribute of disability, but it is shaped by an intersection of different identity markers that include sexuality. In any case and as noted in the introductory chapter, Gomez (2012) states that sexuality forms a core part of being human and it determines both the physical and mental well-being of a person. Closely linked to such an assertion is the ways in which participants draw feminine strategic power from cultural practices of sexual initiation in a quest to express their sexuality, as discussed below.

Drawing feminine strategic power from cultural practices of sexual initiation

In further illuminating their dynamic engagement in intimate partner relationships, most participants narrated that they draw feminine strategic power from cultural practices of sexual initiation and in particular the elongation of labia. For example, Tamara who has partial visual impairment says:

My boyfriend liked my pulled labia. I was happy that I pulled because he liked the sex with me. But I just enjoyed sex for a little bit because I was given AIDS by my boyfriend when I was 21 and I became partially blind and very sick.

The above quote from Tamara's story illuminates the fact that whilst the pulling of labia may hold the potential of enhancing eroticism in heterosexual relationships, the practice may expose participants to HIV infection, as will be discussed later on in this chapter under Theme 2. Most participants illuminate their belief that the primary objective of having elongated labia is to please a man within a heterosexual intimate partner relationship. For example, and as noted in Chapter 5, Chipso is happy that she pulled her labia because it enhances eroticism in her intimate partner relationship with her boyfriend. In another example Mayita, who has a psychosocial impairment and who married a man of Indian/European descent, says:

He loved my labia and he would say, "White women, they don't pull their labia so they are not beautiful". He would say, "Truly African women are beautiful". Whilst

he was fondling my labia, I used to hold his penis like a telephone handset. Even though I am disabled, our sexuality was very well with George.

As discussed in Chapter 2, Global Northern perspectives of feminine beauty are usually linked to slimness, slimming diets, face lifts and plastic surgery among other things (Andrews & Studd, 2005). However, the findings of this study reveal that elongated labia forms a key part of the definition of the beauty of an African woman, thereby indicating that there is no universal way of conceptualising feminine beauty. Some feminists argue that bodies should not be tied to their biological characteristics, because such an approach creates a platform upon which gender inequalities are formed, naturalised and legitimised (Armstrong, n.d.). However, and as exemplified by Chipó's narrative in Chapter 5, and Mayita's narrative as quoted above, most participants are proud of their pulled labia, alongside an argument that even though they may have impairments, they are still able to claim and sustain space in the zone of sexuality by pleasing their male partners.

The above perspectives bring to the fore the concept of normalization as articulated by Meekosha (1998), thereby indicating that although it is common in some African contexts for women to elongate their labia with the aim of enhancing eroticism in their heterosexual relationships (Tamale, 2005; Bagnol & Mariano, 2008a, 2008b), the findings of this study indicate that disability makes a difference. From the perspective of participants, it appears that the practices are also meant to seek to normalize a "deformed" body so that it "fits in" with the normate's contextual framing of being sexually desirable. The irony of the matter is that African literature that covers the subject of elongating labia (Bagnol & Mariano, 2008a, 2008b; Tamale, 2005) is devoid of the voice of disabled women, thereby implying that all women who practice such traditional customs are non-disabled. Yet, the findings of this study highlight the fact that disabled women are also active participants in such traditional sexual practices.

By drawing feminine strategic power from their elongated labia and using such an asset to enhance eroticism in their heterosexual relationships, some participants enhance their attractiveness and create opportunities for themselves in their heteronormative experiences of sexuality. Mako, who has epilepsy says, "*Pulled labia is good because it makes a man to love me more for love.*" Such perspectives bring to the fore the notion of female power, as illuminated by Chiweizu cited in Chukwuma (n.d., p. 3): "...male power tends to be crude,

confrontational and direct, female Power tends to be subtle, manipulative and indirect. Whereas aggressiveness is the hallmark of male power, maneuver is the hallmark of female power.” As Michel Foucault (1976) rightly described it, power is not all about dominance, but power functions on people’s own bodies, in simultaneity with desire and knowledge; power is everywhere as it functions at micro-levels of people’s daily lives.

Whilst the mainstream feminist discourse has generally viewed disabled women as women with individual “tragedies” that require private personal attention, charity or care (Price, 2011), from a critical FDS perspective Garland-Thomson (2005) challenges the perception that disabled women are sub-standard, deficient, excessive, incompetent, unhealthy and useless. In line with such an assertion, it is evident that whilst all participants may acknowledge disability as one of the main social life attributes that frames their identity, some participants take charge of their own bodies and engage in traditional sexual practices that enhance eroticism in their heterosexual unions. Nyasha, who is visually impaired says: *“People think that because I am blind I don’t have pulled labia, but even if I am blind I also want to please my man.”* Whilst one may argue that participants are trying to conform or to “fit in” with the normate’s construction of beautiful African feminine bodies, one may also argue that the women are challenging the normate’s framing of participants’ bodies as defective and useless by doing what every other woman does. Whichever way, the practices interrogate the social model of disability for neglecting the subjects of sexuality and culture and the recognition that different societies have different ways of conceptualising disability and sexuality influenced at most by their cultural belief systems.

The practices of sexual initiation, as exemplified by Chipso’s narrative in Chapter 5, point at another dimension of Foucault’s novel conceptualisation of power. The same applies to the example of Mako who has epilepsy and who says:

...vana tete (aunts/father’s sisters) said, “If you don’t pull you will be like a bottle without its neck and your husband will have a plain and boring vagina and he can easily throw you away, so I pulled so I could make my husband happy when I get married.”

As noted in Chapter 2, Foucault proclaims that power is knowledge in the sense that power/knowledge is exercised to delineate what is possible or not possible to do, thereby

making it only feasible to act in certain ways of knowing (Foucault, 1976; Pylypa, 1998). The sexual initiation practices that are evident in this study can be linked to Foucault's notion of disciplinary power that functions on people's own bodies in simultaneity with desire and knowledge. Under this subject, it is the disciplinary power that acts on a participant's body, in concurrence with the woman's desire to enhance eroticism in heterosexual unions. Such desire is exacerbated by the traditional knowledge that a woman obtains about how she could attain feminine beauty and feminine strategic power. Nevertheless, one can say that the practices of sexual initiation, as reported in this study, indicate a patriarchal construction of disciplinary power whose aim is to generate inferior bodies that are sexually subordinated (Bartky, 1998). However, a contradiction emerges, as some participants report that the disciplinary practices enable them to achieve a sense of "normalcy"; the practices therefore provide the women with a sense of mastery and a secure sense of identity which makes them feel that they are sexually desirable, in a context where they are generally regarded as asexual beings on the grounds of impairment.

One participant, who is Deaf, offers a different perspective about the significance of pulling one's labia. Saru says:

My grandmother said I should pull my labia, but I refused...then she said a woman without pulled labia is just an empty tin which can easily be put in the bin by a husband. If the pulling was done on my face then maybe yes! I would do it because I would be able to look at my pulled face in the mirror and admire it myself. Why should I pull and beautify a vagina which I hardly look at?

It is evident that in line with the assertion made by Bartky (1998, p. 102) disciplinary power is not imposed at gunpoint but it is widely dispersed; there is no "...sergeant in the disciplinary regime of femininity...". As such, disabled women can voluntarily seek discipline through engaging in sexual initiation practices in an attempt to master the rituals of normative feminine beauty, or they may choose not to. Nevertheless, one can argue that whether the women engage in the practices of elongating their labia or not, disciplinary power determines the implications of such decisions; so discipline is not voluntary although the practices are. Furthermore, the fact that in many cases disabled girls are excluded from the practices which represent the sexual initiation of girls into the adult feminine sexual role asserts the notion of the perceived asexuality of disabled girls and women within the disciplinary practices of

sexuality. Whichever way, the finding illuminates the fact that the vaginas of participants are set apart as physical objects that are policed and subjected to various traditional interventions that are meant to fulfil the sexual desires of men, as disability, gender and culture intersect to frame the women's strategic power in their experiences of sexuality.

The findings of this study reveal that although elderly women may facilitate the sexual initiation of girls by teaching the girls to elongate their labia, such practices are not meant to promote sex before marriage. Mako, who obtained traditional sexuality education before she acquired epilepsy at the age of 16, says: *"The grandmothers were teaching us to pull our labia but they said we should not have sex with men in the bush but we wait until we get married."* The argument is that premarital sex brings shame to the girl and her family if she loses her virginity before marriage (Dulobo & Haanyama, 2012). It is therefore evident that post-colonial African societies may still harbour traditional organisations that exercise the stringent management of sexual behaviour (Staples, 2006). However, there is evidence that in spite of such management practices, all participants engage in sex outside of marriage. For example, Tamara, who is partially blind, says:

With my first boyfriend we didn't have sex, with my second we had sex with condoms, then with my third we had sex with no condoms and I got AIDS. I was 21 years old. Now I have another boyfriend who is disabled with polio and he is also HIV positive.

Historically the traditional rule of no sex before marriage in Africa abounds, albeit the fact that pre-marital sex in pre-colonial Africa was in some instances approved, particularly in cases where the coitus took place within the parameters of certain tribal rules (Staples, 2006). However, whilst the traditional rule of no sex before marriage for all women seems to be slackening with "modernity" in post-colonial Zimbabwe, the common practice of sex before marriage among disabled women may be attributed to the fact that participants report that men are usually reluctant to marry disabled women. As noted in Chapter 3, disability is often associated with taboos, witchcraft and evil spirits (Burck, 1989; Mpofu & Harley, 2002; Pasipanodya, 2013) in a context where gender, disability and culture intersect to narrow the chances of marriage for disabled women. Given such challenges, it is evident that instead of sticking to the strict traditional regimen of no sex before marriage, the majority of participants choose to engage in sexual relations that suit their circumstances. As such, I

discuss the sub-theme of efforts that are made by disabled women to enhance eroticism in their intimate partner relationships through the use of vaginal products, below.

Enhancing eroticism through use of vaginal products

There is strong evidence that in their dynamic engagement in intimate partner relationships, most participants use vaginal products to enhance eroticism in such relationships. Mara, who has a spinal cord injury induced physical impairment, says:

*These herbs help women to become “virgins” again and to heat the body because the men say if a woman’s body is cold then the sex is not good. These herbs work well, especially the one called **kasikana** (little girl), because it tightens my vagina like that of a little girl and I can make my man happy for sex. I can’t do without the herbs so my uncle’s daughter brings them for me because with my spinal cord injury it’s not easy for me to go to the **Mbare** market to buy them.*

There is a paucity of literature on the use of vaginal products by disabled women in Africa. Visible in-depth African studies on the topic thus far were done in Mozambique (Bagnol & Mariano, 2008a, 2008b) but such studies make no reference to disabled women. From a FDS perspective Hall (2011) questions the inability of society to reconcile the realities of being disabled, being feminine and being sexual. Nevertheless, the findings of this study indicate that impairment does not deter disabled women from using vaginal products that enhance eroticism in their heterosexual relationships. As exemplified in Mara’s narrative which I quoted above, those who experience mobility problems due to the nature of their impairments often put mechanisms in place to ensure their acquisition of vaginal products. Whilst I may argue that participants are making efforts to achieve contextual sexual normalcy, I could also argue that such efforts symbolise the value that is attached to the use of vaginal products by disabled women in a context which is characterised by complex sexual rules, possibilities and impossibilities.

All participants who use vaginal products illuminate their belief that men generally prefer dry sex as opposed to having a penetrative sexual encounter with a woman who is wet. Mara who has a physical impairment says, “*You know men don’t care if you are disabled or not, they can say **mukadzi uyu imvura dzega dzega** (this woman is just water and water alone)*”. It is evident that disabled women make perpetual efforts to use vaginal products to make their

vaginas dry in preparation for dry sex. Whilst literature from the Global North has stated that disabled women often internalise the way in which society perceives them as “damaged bodies” and asexual beings (Begum, 1992; Fine & Asch, 1985), the findings of this study point to the contrary. There is evidence that by making use of vaginal products to enhance eroticism, participants position themselves as sexual beings. However, from a FDS viewpoint, Wilkerson (2011) queries the manner in which heterosexual women appear to be directed to submit, or to submit on their own accord to hierarchies that may systematically disadvantage the women themselves.

The use of vaginal products by participants can also be linked to Foucault’s (1976) perspectives of disciplinary power which I will not repeat under this sub-theme because I have already outlined them above. However, I point out that as articulated by Chinweizu in Chukwuma (n.d. p .3), “...it is easy to be misled into thinking That a female form of power does not exist at all; and even when female power is Recognized, it is easy to dismiss it as power of an inferior type, just because it is not Hard, aggressive or boastful like the highly visible male form.” Yet, it is evident that participants ingeniously draw feminine strategic power from the use of vaginal products, as participants seek to satisfy the demands of male sexuality and to follow its disciplinary practices in a context where they are competing with non-disabled women for male intimate partners. However, the value that is attached to the use of vaginal products by participants means that participants may be confusing sexuality with penis/vagina coitus, oblivious of the fact that sexuality can be expressed in a myriad of ways. As postulated by Redelman (2008), sexuality does not necessarily mean the conflation of male and female genitals but it also includes friendship, cuddling, masturbation, vaginal self-stimulation, relaxation, touching and kissing (Madunagu, 2007; Redelman, 2008). However, prevalent within the family of contextual heteronormative practices is the sub-theme of reproduction and motherhood, which I discuss below.

Reproduction and motherhood

There is strong evidence that all disabled women who have had the experience of giving birth to a child or children faced immense challenges in the arena of reproduction and motherhood. For example, and as noted in Chapter 5, when Tsitsi, who has a polio induced physical impairment, delivered her first son, her mother requested healthcare staff at a local village clinic to remove her reproductive organs so that she would not be able to have any more children because she has a physical impairment. From an angle of FDS, Garland-Thomson

(2005) and Lloyd (2001) state that disabled women are not only mythically considered as asexual beings but they are also regarded as unattractive and unbefitting as parents. Even in cases where disabled mothers may have children, particularly in the Global North, there is the risk that such children may be taken away by social welfare departments from the disabled mothers on the grounds that the women have impairment (Corbett cited in Traustadóttir, 1990), hence they are not suitable to be mothers.

This study revealed that a Deaf participant lost her babies during two separate child delivery processes. Rudo says:

*All my babies died because the doctors and nurses could not speak sign language. In **Murehwa** (rural hospital) I lost a baby girl, I was trying to talk to them but they could not hear. In **Harare** (city hospital) my big baby boy also died during delivery. I could read the nurse's lips and I saw that she was saying push! push! push! but for me to tell her anything, I couldn't because she could not understand sign language...I think they are not taught in their school how to speak sign language, so they are not educated.*

It is clear that Rudo attributes the loss of her two babies during separate child delivery processes to the fact that healthcare staff who attended to her could not speak sign language. Literature from the Global North states that such professional incapacities create barriers for a Deaf person in the hearing world (Becker & Jauregui, 1985). Communication barriers increase feelings of discomfort and humiliation which can be curtailed by the implementation of practices that ensure the inclusion of neglected populations so that their silent voices can be facilitated (Kathard & Pillay, 2013). Although there could be other reasons why Rudo lost her babies, it appears that she is not privy to such reasons because healthcare staff was unable to communicate with her in the appropriate language. Devoid of an explanation of what really went wrong during her child delivery processes, Rudo is left with no choice but to conclude that healthcare staff were unable to communicate with her because they are not educated.

There is evidence that disabled women who have not had the experience of giving birth to children, aspire to have their own children. For example, Gamu, who has intellectual impairment, recounted that she will soon have children with her boyfriend who also has intellectual impairment. Referring to the gender affiliation and the number of children she

intends to have, Gamu said: *“I don’t like boys, I like girls so I will have two girls and I will give them porridge and carry them on my back.”* The experience of becoming a parent can be both gratifying and difficult for all people and yet people who have intellectual impairments have at a world wide scale been historically denied space in marriage and motherhood (Mirfin-Veitch, 2003). However, whilst people with intellectual impairments may need unique and prolonged support in raising their children, Mirfin-Veitch (2003) states that they can also be good parents. In spite of such a reality, the same author notes that the general belief of people in most societies is that intellectual impairments are genetically transferred; hence people with such impairments will transfer the impairments to their offspring. The other school of thought is that intellectually impaired women may never be able to take care of their children because they are in need of care and support for themselves, as well as in raising their children.

As illuminated in Chapter 5, Nyarai, who has an intellectual impairment, stated that she has sex with her boyfriend in the chicken run on most days of the week and she intends to have four babies, whilst her boyfriend desires to have 14 children with her. However, Tatenda, who has an intellectual impairment and who lives at the same mental healthcare institution with Nyarai, says:

The condition here is every woman must have her tubes tied. So all these women you see here with Down syndrome, Schizophrenia or what, their tubes are tied. I was forced to get my own tubes tied when I came here but now I am not worried because I am menopause.

The same normative system which assigns disabled women to an asexual status on the grounds of their bodily impairments is the same system which denies disabled women the right to motherhood (Boylan, 1991). The practices illuminated by the examples of Nyarai’s narrative in Chapter 5 and the narrative of Tatenda, which I have quoted above, resonate with the FDS perspectives of Wilkerson (2011), who states that the sexuality of “othered” people is usually regarded as socially problematic, a practice which in itself is a symbol of oppression. In addition, “othered” groups often confront coercion, limitation, and punishments and they are often denied access to significant information that is relevant to their sexuality in contexts where bodily perfection is linked to sexuality. In relation to this study, such practices may resemble a serious violation of the human rights of disabled women.

From a human rights based perspective, Article 23 (c) of the United Nations Convention on the Rights of Persons with Disabilities, (CRPD), (United Nations, 2008) clearly states that disabled people should be allowed to retain their fertility in the same manner that every other person does. In addition, Article 23 (b) of the same Convention states that disabled people have a right to responsibly and freely decide on the number and spacing of their own children. The example of the narratives of Nyarai (Chapter 5) and Tatenda as quoted above, bring to the fore the proclamation that the recognition of rights and the realisation of such rights are two different things that may not be simultaneously achieved (May & Simpson, 2003). There is strong evidence that it is not only intellectually impaired women who are regarded by the normate as unfit to be parents but women with different impairments as well. For example, Rudo says:

Because I am 50 years old, Deaf, partially blind and childless, they call me a disabled witch who cannot have children...but if I get a good man, I would like to marry...so that I have a child because although I am 50, I am not yet menopause...

From the viewpoint of FDS, the above narrative resonates with the concept of the normate which, according to Garland-Thomson (1997), symbolises a construction of an identity by those who consider themselves to be “normal” enough in relation to their bodily features and capital. Such people assume they can take authoritative positions and wield the power that such positions award them to frame what they call “norms”. Such practices often serve to silence the voice of disabled women within frameworks of the fluid concepts of “normalcy” and “deviancy”. However, a blanket assumption which relegates all disabled women to a category where they are perceived as unsuitable for marriage and parenting may result in the discrimination and exclusion of disabled women in mainstream support and services in the arena of sexuality (Mirfin-Veitch, 2003). Regarded by the normate as “abnormal”, it is also evident that disabled women may be denied access to maternity and motherhood information and services, as discussed below.

All participants who have congenital impairment or who acquired impairment before they started giving birth to children reported that they were unable to access appropriate information regarding family planning, contraceptives, reproduction or motherhood from contemporary healthcare centres. For example, Mako says: *“The nurses, they didn’t tell me so I didn’t know that epilepsy medicine weakens the power of the contraceptives that I was*

taking, so three months after delivering my first child, I fell pregnant again.” Whilst access to information may be a problem for both disabled and non-disabled women, it is evident that disability makes a difference in the sense that whilst generic healthcare approaches may apply to all women, disabled women may need unique reproductive healthcare which is tailor made to suit specific impairments. In addition, drawing from a medical study carried out in Canada by Basson (1998), one can argue that the side-effects of drugs, and investigations into sexuality functioning, are significant elements that need to be carefully attended to by healthcare professionals who interact with disabled people. However, a study carried out by Thomas (1997) in the UK revealed that disabled women often encounter gender oppression and disablism in healthcare centres in a myriad of ways. The findings of this study indicate that such scenarios may be detrimental to the well-being of disabled women.

It is evident that the popular cultural conceptualisation of disability which associates disability with evil spirits, taboos and witchcraft, as illuminated in Chapter 3, may be taken into contemporary healthcare centres by staff. For example, Saru says:

*If I deliver a baby no one tells me how to care for it, nurses are just angry that I am Deaf and having a baby. They think I have evil spirits because I am disabled. They cannot speak sign language so they teach me nothing...I go home, there is no one to teach me, my father and mother died of AIDS. The babies of some of my Deaf friends have died because no one teaches them to take care of the baby...I was lucky because at **Kuwadzana 4** clinic there was a nurse who has two Deaf children so she helped me to deliver my baby, but she did not tell me how to take care of it, but I am happy that I figured it all out on my own.*

As previously noted, the development of the conceptions of the features of the language that a client uses within medical settings is important (Barnett, McKee, Smith, & Pearson, 2011; Flores 2006; Kathard, 1998). However, there is evidence that in the context of this study, the presence of sign language speaking staff in maternity wards may not be a strategically planned and implemented arrangement, thereby creating what may appear to be an attitude of indifference on the part of healthcare staff. A study carried out by Thomas (1997) reveals that the situation may be different in the UK where midwives tend to impose unsolicited, aggressive, disturbing and disempowering help on disabled women. Thomas states that in such instances “help may become unhelpful”, thereby undermining the confidence of

disabled women in relation to their capability of being good mothers. However, it is striking to note that in the context of this study the experiences of neglect in healthcare centres may also be prevalent at home, where men who father children with disabled women are reluctant to provide for both the disabled women and their children, as discussed below.

It is evident that all participants who have children are not given child support by the men who fathered the children. For example, Tsitsi's narrative in Chapter 5 shows that the man who fathered her two sons did not provide for the children until the time of his death when the children were about 15 and 12 years old. As illuminated in Chapter 5, Danai's son, who in 2014 was 17 years old, had never seen, related to or been financially supported by his father; a Civil Engineer by profession. Mara provides another example:

When I got spinal cord injury, he took all the money and he went to live with his "small house" (mistress) leaving me and the children to suffer in poverty. He hated both me and my three children because I become disabled; I have two girls and a boy. So I started to buy and sell second hand clothes and I put a stall at the gate of our house.

It is striking to note that some men who would have been providing for their children may discontinue such provision when the mother acquires impairment. As illuminated in Chapter 3, within most African contexts including in Zimbabwe, boys are more valued than girls because they are symbolic in uplifting a man's tribe (Choruma, 2007). However, the findings of this study reveal that disability adds an additional layer of disadvantage for participants and their children; regardless of the gender affiliation of the children, some men are reluctant to provide for children who have disabled mothers, in a situation which appears as if children are despised and stigmatised for their mothers' impairments. Such a scenario could be attributed to the fact that disability is often associated with taboos, witchcraft and evil spirits, and in such cases gender, disability, and culture may intersect to result in participants being left to fend for their children on their own. However, there is evidence that participants who find themselves in such a situation often claim their agency and establish informal small-scale income generating projects that enable them to provide for their children, thereby giving rise to the situation which is discussed below.

Even if some participants would want the type of family life in which they could avoid the public space and yield to men who provide for them and their children, it appears that such an option is not available to participants on the grounds that they have impairments. A study of the patriarchal experiences of Afghan women under the Taliban revealed that the "... patriarchal project does have the support of some women, who find security and status in family life and who prefer not to have to negotiate in the public sphere" (Moghadam, 2002, p. 28). Australian studies undertaken by Meekosha and Dowse (1997a, 1997b), indicate that disabled people and particularly disabled women, are usually regarded as the inhabitants of the private sphere. However, participants narrate that their choices are limited; circumstances force participants to occupy public space as they go in search of economic opportunities that enable them to fend for themselves and their children. I therefore call for a further analysis of the strategies that disabled women employ in dealing with the diversity of patriarchy, as the women negotiate their experiences of sexuality in so far as the raising of their children is concerned. Closely linked to this first theme of the dynamic engagement of participants in intimate partner relationships, is the second theme of gender based violence (GBV) which is embedded in such relationships and which I present below in an effort to highlight its reported prevalence in the experiences of sexuality of disabled women in Zimbabwe.

Theme 2: Gender Based Violence (GBV)

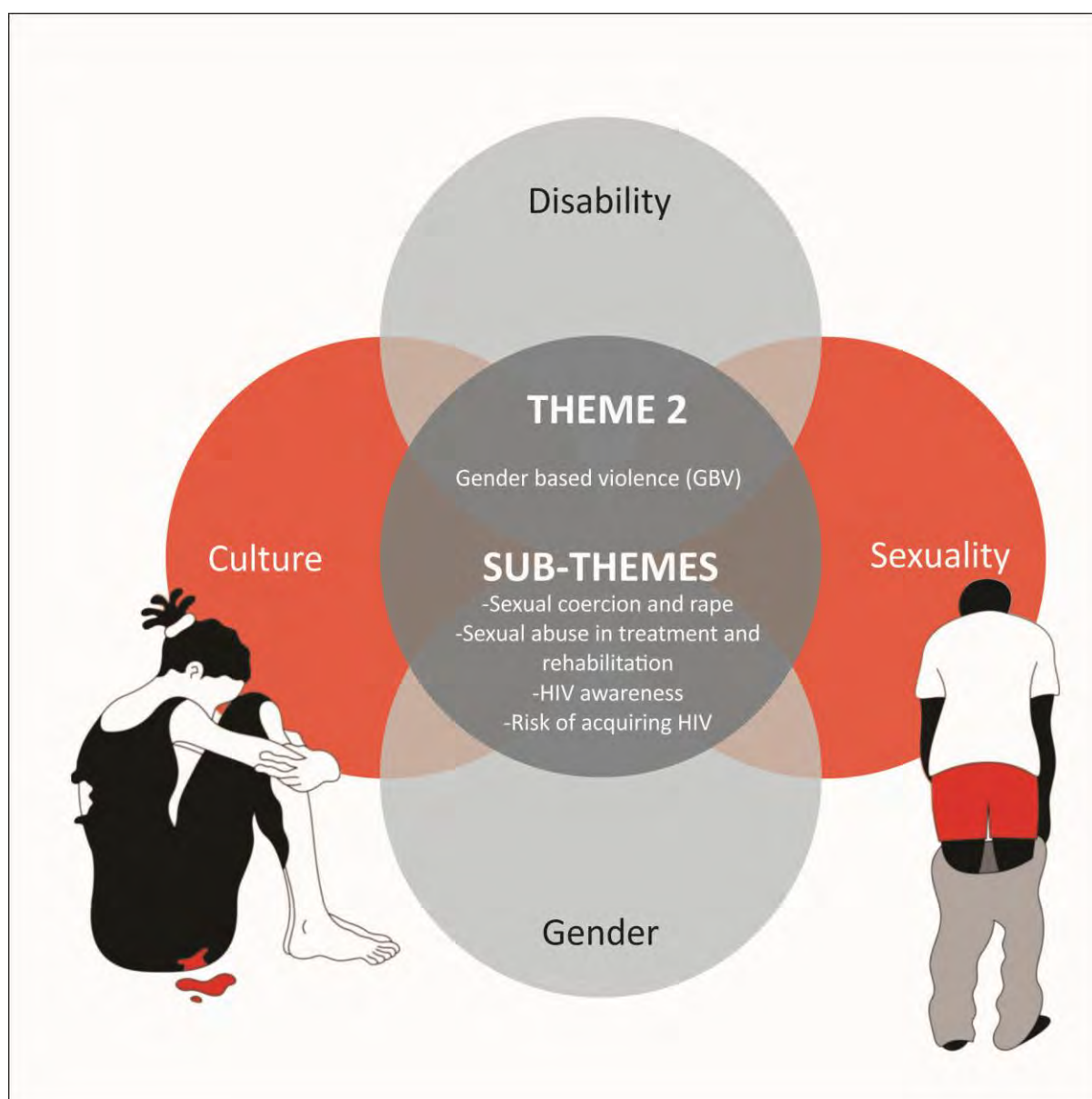


Figure 4: Gender Based Violence (GBV)

Figure 4 above, illustrates the theme of gender based violence (GBV) and its integral sub-themes of: a) sexual coercion and rape; b) sexual abuse in treatment and rehabilitation; c) HIV awareness; and d) the risk of acquiring HIV. Below, I discuss the sub-theme of sexual coercion and rape.

Sexual coercion and rape

The sub-theme of the prevalence of sexual coercion and rape within families and communities came up in one way or the other in most of the interviews. For example, Tatenda, who has an intellectual impairment, was repeatedly raped by her stepfather. "My

stepfather started to rape me when I was 11. He broke some things on my body, because my hole was too tiny and his penis was too big.” In addition, Tatenda was also used by her stepfather as a prostitute:

It started when I was 13, he was paid when I have sex, a different man each night...One day I overheard him saying, “I have a very young one and she is very cheap, does anyone want her?” My mother knew about it but she did nothing...until I turned 18 and I started to defend myself, until me, my brothers and my sisters were taken by the Government into a children’s home.

Research has indicated that GBV which includes sexual coercion and rape is a worldwide problem, to which many women are vulnerable, including those in the Global North (Russo & Pirlott, 2006). Whilst the visibility of literature on GBV against girls and women worldwide is unquestionable, the research that has been undertaken on sexual coercion and rape that targets disabled women in African contexts, including in Zimbabwe, is limited. Global Northern literature has indicated that impairment may cause a person to be at an increased risk of sexual abuse in cases where they depend financially, emotionally or physically on the perpetrator (Plummer & Findley, 2012). In the context of this study, it is evident that poverty, gender and disability may intersect to create vulnerabilities to sexual abuse for disabled girls and women thereby exposing them to the likelihood of HIV infection. Tatenda says:

My mother was not working, she had two children from my father and five children from my stepfather, total seven children, and three of us, the girls, disabled, two of us with mental disability and my other sister in a wheelchair with polio. My stepfather had sex with the three of us. I think my mother was sick somehow because she just kept quiet.

It is possible that Tatenda’s mother could have maintained silence about the sexual abuse that was perpetrated by her husband against Tatenda and her siblings with perhaps the intention of protecting her abusive husband who was the sole breadwinner of the big family. It is likely that economic welfare took precedence over the significance of protecting the girls against sexual abuse which carried the risk of HIV infection. Such a scenario provides evidence that poverty adds another rung to the vulnerability ladder of sexual coercion and rape among

participants. It is therefore not surprising that from an FDS perspective, the discussion advanced by Garland-Thomson (2005) on disabled identity has come under criticism for assuming that disabled identity is not part of social, economic and historical contexts. Garland-Thomson (2005) asserts that disability is the most universal of human conditions which is an important part of a person's embodiment and a way of interacting with the universe. However, from another angle of FDS, Erevelles (2011, p. 119) raises a question: "How can acquiring disability be celebrated as 'the most universal of human conditions' if it is acquired under oppressive conditions of poverty, economic exploitation...and lack of access to adequate health care and education?" The findings of this study reveal that the intersection of disability, sexuality, poverty, class, race, gender, culture and nationality may increase the vulnerability of disabled girls and women to GBV and HIV infection, hence isolating a disabled identity from social, economic and historical contexts could be futile, as further highlighted by the discussion below.

The other reason why Tatenda's mother could have maintained silence on the sexual abuse that Tatenda and her siblings were experiencing could have been that women in most African countries are discouraged from talking openly about sex (Reid & Walker, 2005). As highlighted in Chapter 3, sexuality in most African contexts is usually regarded as a private, sacred, personal, private bedroom matter that should be kept out of the public domain (Interesting Interests, 2009; Tamale, 2011). *"For seven years, no one talked about the sex that my stepfather was doing with me and my two sisters, the guy was not arrested by anyone, but now I think he is dead."* The findings of this study resonate with the assertion that if sexuality is swept under the carpet, it becomes easier to use it negatively in violence, abuse, control, oppression, to cover up sexual scandals and to misinform one another (Interesting Interests, 2009). Such an assertion is supported by the narrative of Tatenda whose stepfather got away with abusing Tatenda and her siblings for seven years, in a context where silence was maintained on the sexual abuse practices as was the case in the other narratives, as illuminated in the examples below.

There is strong evidence that all participants who had the experience of rape did not report the rape at all or they told a close family member who swept the incident under the carpet. For example, and as noted in Chapter 5, when Danai who has albinism was raped and impregnated at the age of 17, she and her family did not report the incident to the police, but Danai was directed by her family to stay in the village until she delivered her baby. Such a

scenario is not surprising, considering that literature reveals that the common practice for people in most African communities is to seek to realise their rights within the communal space rather than by representing themselves as individuals (Izugbara & Undie, 2008). Within some African contexts, bodies do not belong to the individual but they belong to the entire family and community, influenced at most by cultural ideologies (Chavhunduka, 1998; Izugbara & Undie, 2008). An individual who seeks to realise his or her rights at individual level will therefore be breaking out of the traditional norms, thereby running the risk of losing the support of her family and community in a social context which is further discussed below.

Existing pronouncements on human rights pertaining to sexuality and disability are crafted along the lines that the body belongs to an individual. However contrary to such perspectives it is evident that in the context of this study, and as exemplified by the narrative of Danai and Chipso in Chapter 5, the prerogative of selecting a course of action following a rape experience does not lie with the affected individual but it rests with the family at large. The scenario is contrary to common practices in the Global North where some literature in the US, for example, has recorded that the majority of rape reports (about 70.2%) are made by the victims themselves and not by friends, family members or other third parties (Tjaden & Thoennes, 2006). Such practices indicate that in Global Northern societies, the responsibility to decide on a course of action following a rape incident rests squarely with the affected individual. Whilst in this study there is evidence that decisions pertaining to rape incidences are generally made at family level, there is also evidence that some participants at individual level may desire to know how they can obtain assistance from the criminal justice system in the event that they are raped. Saru says:

If I am raped it's hard to report. The police cannot talk sign language. Some of my Deaf friends, both the mother and the child are raped, but the police are not talking sign language and there is no interpreter so we just keep quiet.

It is evident that Deaf women may experience communication problems, even if they may desire to seek help from the criminal justice system following a rape incident. Deaf people are more vulnerable to rape as they are unable to scream for assistance and Deaf people may also encounter communication barriers when they approach criminal justice officials for assistance (Hanass-Hancock, 2009a; Groce & Trasi, 2004). In a large number of nations across the world, disabled people are not allowed to make reports to the police, to take oath

or to testify in courts of law (Groce & Trasi, 2004). The reason is that officials usually assume that disabled people are either confused or they could be part of some mix-up (Sobsey cited in Groce & Trasi, 2004). To my knowledge disabled people in Zimbabwe are not officially prohibited from making police reports, but what is evident in the findings of this study is that perhaps the local justice delivery system lacks knowledge and skill about how to handle cases of people with different impairments. Such a scenario resonates with the reality that family members may also respond in a blaming manner to incidences of sexual coercion and rape, as discussed below.

There is strong evidence that when some participants are raped, they may not disclose the rape incident to their families, in an effort to avoid the blaming attitudes and punishments that such disclosure may attract at family level. For example, Mako, who has epilepsy, concealed a rape incident for fear of being punished by her guardian:

*I lived a life of too many punishments, if you haven't swept the house you get beaten, if you haven't washed the dishes you get beaten, so when I was raped I just kept quiet because I thought that my **mainini** (mother's sister) would beat me up.*

In another example, when Rudo, who is Deaf, was raped when she was aged 16 by her aunt's non-disabled male friend, she did not tell anyone about the incident for fear of being blamed by her family for the occurrence. *"He was my aunt's friend and he said, 'Let me show you where I stay'. We got there and he locked the door and he raped me. I didn't tell my aunt because I was afraid that she would shout at me."* Literature from the Global North reveals that rape cases are usually not reported by victims because the victims fear further harm from the perpetrator, who may physically assault them or threaten them with death during the rape encounter (Tjaden & Thoennes, 2006). However, participants who did not report rape in this study revealed that they were afraid of being blamed and punished by their own family members for the rape. As discussed in Chapter 3, the common practice in Zimbabwe is that if a woman is raped outside of marriage, blame is usually put on the woman rather than on the male perpetrator (Zinanga, 1996). The widespread belief is that the woman may have dressed inappropriately, thereby arousing the sexual feelings of men.

There is evidence that if a woman is raped before she acquires impairment and if she reports the incident to family members, the family may instigate a process that will see the victim

marrying the rapist. For example, Chipo's narrative in Chapter 5 reveals that when she was raped at the age of 17, before she acquired physical impairment following a spinal cord injury, arrangements were made for her to drop out of school and to marry the perpetrator when she was 18 years old. It is also evident that if a disabled woman is raped she may expect the rapist to marry her as exemplified by Tsitsi's narrative in Chapter 5. Although there are no laws in Zimbabwe which exempt a rapist from prosecution if he marries the victim, the findings of this study reveal the prevalence of such incidences within traditional practices that may hide such occurrences from the judiciary system. It may be that poverty exacerbates such practices; for example, Chipo reported that her family of her father's three wives and 24 children is poor. It therefore means that perhaps the payment of *roora* (bride price), even by a rapist, could have held the promise of pulling the family out of poverty considering that the *roora* usually consists of cows and cash.

Global Northern literature indicates that rape is clearly a crime (Tjaden & Thoennes, 2006), under which marrying a victim is not regarded as justice. It is clear that within the context of this study, gender, culture and sexuality may intersect to make the rape incident right if the perpetrator marries the victim. One could attribute such a scenario to the fact that virginity is a highly prized possession in some African countries including in Zimbabwe (Zinanga, 1996). Similar to practices that have been observed in other African countries, such as in Morocco, there may be fear that the rape may spoil the honour of the victim and her family and no man may want to marry her in future, hence she is better off marrying the man who breaks her virginity, even through rape (The Independent, 2012). African countries such as Algeria and Morocco have recorded penal codes which exempt the victim from prosecution if he marries the victim, and in such nations the courts may even suggest marriage between the victim and the perpetrator (Amnesty International, 2004; The Independent, 2012). Although virginity attitudes in Zimbabwe may be changing in line with modernity, the findings of this study reveal a prevalence of traditional practices that use marriage to cover up sexual scandals, alongside a belief that such practices protect the morality, interests and dignity of the woman and her family.

The findings of this study also reveal a unique conceptualisation of rape, which presents challenges in understanding the term from the perspective of participants, thereby indicating that the term does not mean the same thing to all people in all societies. There is evidence that some participants only realise that they have been "raped" when the "perpetrator" refuses

to marry them after a forced sexual encounter, as exemplified by the narrative of Tsitsi in Chapter 5. As noted in Chapter 3, a study carried out in South Africa revealed that some men tell women that there is no point in having a love relationship if people cannot have penetrative sex and that people who are “in love” should be able to have sex as much as possible (Wood & Jewkes, 1997). However, the findings of this study reveal that participants take it a step further to associate sex with both love and marriage, to the extent that even after enduring forced sex, participants may still interpret the “rape” to mean love and an opportunity for marriage, as further discussed below.

The above perspective is fulfilled in some cases where, for example as discussed in Chapter 5, the narrative of Chipso illuminates her two decades of a blissful marriage which she earned after dropping out of school and marrying the man who raped her when she was 17, before she acquired a physical impairment following a spinal cord injury which occurred when she was aged 38. However, there is also evidence that the reverse is true for other participants such as Tsitsi, who was raped and impregnated twice by the same man who refused to marry her, in spite of the fact that Tsitsi who, as highlighted in Chapter 5, was expecting marriage from the rapist. Such a form of sexual practices may be attributed to a kind of gendered power relations which is prevalent in heterosexual relationships (Kalichman et al., 1998; Wood & Jewkes, 1997; Russo & Pirlott, 2006). However, it is evident that from the perspective of participants, there is an obscure line which divides sex, rape, love, and marriage. It is evident that being raped may mean rape for what it directly is, or rape may mean sex which women may interpret as love and a kind of love which may lead women to expect marriage from the rapist. Such a scenario makes it difficult for some participants to immediately ascertain which of the various aspects of sexuality is really going on, but it appears that they always do, and hence draw conclusions about the experiences but much later on. Closely linked to the sub-theme of sexual coercion and rape which I have discussed in this sub-theme is the vulnerability of disabled women to sexual abuse in treatment and rehabilitation processes, as discussed in the following sub-theme.

Sexual abuse in treatment and rehabilitation

The findings of this study reveal that the prescriptions that are issued by some traditional healers and religious prophets for curing impairment increase the vulnerability of some disabled women to sexual abuse, in a context where impairment is regarded as a calamity

which must be eliminated at all costs. Under this sub-theme I use the example of Mayita who has a psychosocial impairment to illustrate such prevalence. Mayita says:

When I went to traditional healers, I saw that the healers tell men that if they are sick with epilepsy or HIV, they can have sex with a disabled woman and get healed, or if the men want to get rich they should do the same. When my husband left, a lot of men wanted to have sex with me. I think they were trying to get all these things that a traditional healer promises, because these men know that I have a mental disability.

Local literature indicates that some disabled women are targeted for rape by men who are infected with HIV, alongside a belief that sexual intimacy with a virgin cleanses the men of HIV (Choruma, 2007). The idea stems from the assumption that disabled women are asexual beings hence they are virgins and appropriate targets for the practice of “virgin cleansing” of HIV. The belief is that the HIV virus is then transferred from the person who is infected to the disabled individual (Groce & Trasi, 2004). The findings of this study take it a step further and indicate that traditional healers prescribe sex with disabled women not only as a cure for HIV, but also for curing epilepsy and for getting rich. From a FDS perspective, Garland-Thomson (2011) illuminates a form of conceptualisation of disability, which considers some bodies to be less important than others, in a context where disability is a system which denigrates certain bodies. As noted by Garland-Thomson (2005), human differences are intertwined with social meanings that justify practices of marginalisation and discrimination which shape the lives of both non-disabled and disabled women. It is evident that the social meanings that are attached to disability in this study, justify practices that exacerbate the vulnerability of disabled women to sexual abuse.

Literature thus far is pointing at the virginity of a disabled woman as the perceived attribute which cures one of HIV (Choruma, 2007; Groce & Trasi, 2004). However, the findings of this study indicate that it is not solely the virginity of the woman that makes her an appropriate nominee for HIV cleansing rape, but her impairment as well. For example, Mayita, whose narrative I have quoted above, is clearly not a virgin by virtue of her being a divorced mother of two, but she narrated that when her husband deserted her, several men who knew that she has a psychosocial impairment pursued her for sex. She believes that such men wanted to benefit from traditional healers’ prescriptions which direct sex with a disabled woman as a cure for HIV and epilepsy and for the acquisition of material wealth. There is

evidence that in such cases the impaired feminine body is regarded as being primarily valuable for the benefits that its sexual consumption brings to men. It is evident that an intersection of disability, culture and gender frames the experiences of sexuality of participants in such cases. The finding interrogates the social model of disability for taking a masculine focus and neglecting the distinct concerns of women and disabling social relations in sexuality, thereby silencing the voice of disabled women and increasing their invisibility in disability theory.

Having also spent long periods of time with religious prophets whilst seeking miraculous healing for psychosocial impairment, Mayita says:

I was required to spend days at the homesteads of prophets for treatment. A prophet had sex with me for four months before I went back home. Some prophets demand sex in exchange for healing. They say if you want the avenging spirit to go away so that you can be well, you have to have sex with me.

Mayita gave an explicit example of a treatment procedure that she experienced at a religious prophet's homestead:

*He said the "holy" oil he uses to heal can only work if it is applied to his penis and then put in my body through my vagina, because the oil has to go **kumuromo wechibereko** (to the mouth of the uterus) and he can only do it through his penis. So he puts the oil on his penis, then he puts his penis in my vagina and he says that is the healing for mental disability. I told my family about the treatment method and they said I have to do it, if I want to get well because the prophet takes instructions **kunaMwari** (from God).*

There is a dearth of literature which explains the role that is played by religious prophets in the national healthcare delivery system. However, if the cure for impairment is deemed to be taking long via other modes of treatment, the situation is deemed as being very difficult to the extent that it goes beyond the resolution of humanity (Burck, 1989). As such it is submitted to **Mwari** (a supernatural God), under whose "constituency" religious prophets claim to fall. Among other things, religious prophets claim that they can use the same powers that Jesus Christ used, as depicted in the Bible, to make the blind see, the deaf hear and enable those

with physical impairment to realise complete and miraculous bodily recovery (Mpofu & Harley, 2002). From a FDS viewpoint, Garland-Thomson (2005) questions the wisdom of perspectives which seek to resolve the “problem” of impairment and disability through treatment practices that seek to normalise bodies. Contrary to such a viewpoint, the findings of this study reveal perpetual efforts to cure impairment, albeit in patterns which are not static but which are largely influenced by specific moments in the life of the disabled woman. The discussion under this sub-theme of sexual abuse in treatment and rehabilitation processes is closely related to the sub-theme of HIV awareness which is critical in mitigating the negative impact of such abuse, as discussed below.

HIV awareness

The findings of this study illuminate a presence of vibrant HIV awareness programmes in Zimbabwe, considering that most participants (except for some participants who have intellectual impairment) displayed general knowledge about the prevalence of the pandemic, albeit the exclusion of all participants from direct participation in HIV programmes. For example, Nyasha, who is visually impaired, says:

I have learnt a lot about HIV through the radio, so I will not have sex with my boyfriend who is refusing to go for HIV test. My boyfriend suggested the use of a condom, but because I am blind it will be hard to see if he is wearing the condom well or if he digs a hole in the condom, I can't see.

Literature from the Global North indicates that people fear the repercussions of HIV infection; hence decisions are taken with care as individuals seek to protect themselves during sexual interactions (Kelly, 2004). Whilst a high rate of HIV/AIDS awareness programmes has been recorded in Zimbabwe (Living Zimbabwe, 2008), there is also evidence that some participants are not aware of the prevalence of HIV prevention or treatment interventions. As noted in Chapter 5, Nyarai, who has an intellectual impairment, was curious when she heard her female house matrons talking about sex and a condom, but at the age of 29 she had not seen a condom before or acquired knowledge about its functions.

As indicated above and as also highlighted in her narrative in Chapter 5, it is evident that although Nyarai is sexually active, she has not been equipped with any sexuality information which includes HIV prevention and treatment strategies. Nyarai's reference to her

boyfriend's penis and her own "penis" in penis/vagina coitus indicates that she had not by the age of 29 been equipped with appropriate sexual vocabulary. Such a scenario points to the fact that some disabled girls and disabled women are not afforded appropriate sexual and HIV/AIDS information, perhaps on the grounds that they are generally regarded as asexual beings. From a FDS perspective, Wilkerson (2011) argues that "Othered" groups often confront coercion, limitation, and punishments, and they are often denied access to significant information that is relevant to their sexuality. For example, Saru who is Deaf says:

...there are no people for sign language in HIV, even for the blind or the wheelchair...the HIV testing centre is on the second floor of that Nkwame Nkrumah (city building), and the elevator died a long time ago. How can a wheelchair get up there? Surely it doesn't make sense.

The above narrative indicates that as previously mentioned there is a lack of HIV services that are tailor made to suit disabled women and yet such women are also at risk of acquiring HIV. Participants report that HIV testing centres are not strategically located and planned to suit service provision for disabled people. There is evidence of a lack of HIV information in appropriate formats such as Braille for the blind and sign language for the Deaf. There is evidence that the widespread HIV programmes have so far been unable to address critical gender and disability issues given that all participants reported their engagement in unsafe sexual practices. Tamara says:

*I just agreed to have sex with him but I knew that he has AIDS but I just said it doesn't matter because I also have AIDS, but then I got very sick and I almost died. I spent two years in the intensive care unit of **Parirenyatwa** hospital and it was horrible because I watched other people coming in and dying in my face.*

Tamara's narrative illuminates the fact that the view that disabled women are not vulnerable to HIV infection and re-infection is misplaced. There is therefore a need to consciously include disabled women in HIV awareness, prevention, testing and treatment programmes. Advocacy and public education initiatives which promote equality and equity in the provision of health related information and services are required. However, Wazakili, Mpofu, and Devlieger (2006) argue that the sexual choices and decisions that disabled people make are not necessarily based on what the people may know about HIV, but the need for love and

belonging may be more important than the idea of practising safe sex. Whilst Haram (2005), and Wazakili, Mpofu, and Devlieger (2006), have noted that the availability of HIV information does not automatically result in safe sexual practices, one may argue that it is better to have the information and to decide not to use it than not to have it at all. The idea is to ensure that sexuality and HIV information and services are accessible to all human beings in order to reduce the risk of acquiring HIV, which I discuss in the following sub-theme.

Risk of acquiring HIV

The high rate of HIV/AIDS awareness in Zimbabwe has been credited with the reduced rate of men's desire for casual sex and a preference for quasi-formal relationships such as "small houses" in which they feel safer (Living Zimbabwe, 2008). Rudo says, *"I didn't know that my husband who is also Deaf like me was having sex with his 'small house' who was renting a room behind the house that we lived in."* The findings of this study reveal that there is strong evidence that "small houses" may be key drivers of the spread of HIV; hence it is possible that some men could be enjoying a false sense of security. In another example and as highlighted in Chapter 5, Chipo, who has a physical impairment, suspects that her husband who has been having sex with several "small houses" following Chipo's spinal cord injury induced impairment, is now HIV positive. However, after being sexually rejected by her husband, Chipo claimed her agency and she became a "small house" of a married man with whom she is having unprotected sex with.

The sexual route that Chipo decided to take can be explained by the observation made by Chappell and Wirz (2003) in a study undertaken in Sri Lanka among people with spinal cord injuries. The study revealed that people who are discharged from hospital following the acquisition of impairment require a lot of support to enable them to recover or progress with their sense of satisfaction in life (Chappell & Wirz, 2003). Perhaps after being rejected by her husband, Chipo decided to seek such support from the extra marital intimate relationship. However, the irony of the matter is that the HIV status of Chipo, her husband, her husband's "small houses", her boyfriend and her boyfriend's wife remains unconfirmed. Some authors (Chingandu, 2005; Living Zimbabwe, 2008), have however indicated that research by HIV prevention experts has indicated that "small houses" are a main driver of the pandemic and one does not need to be a leading scientist to understand why? I discuss some of the cultural practices that may also be key drivers of the spread of HIV, below.

As illuminated in Chapter 5, Chipso narrated that when she acquired a physical impairment, her father offered her younger sister as a second wife to her husband under the customary practice of *barika* (formal polygamy). Local literature reveals that polygamous arrangements hold high potential to fuel the spread of HIV/AIDS in Zimbabwe (Muchena in Kwaramba, 2011). The findings of this study reveal that disability, gender and culture can intersect to increase the vulnerability of a disabled woman to HIV infection. In another example, Mara says:

*My husband came back from his “small house” after five years and he said, “I am sorry, I was given AIDS by my ‘small house’ so if I die please continue to look after our children.” He said, ‘You are my wife, I paid **roora** (bride price) for you because I love you.’ He killed a cow and we started to be happy again and we were eating the meat. Then we started to have sex again, I didn’t think about HIV or condoms because **ndakangofara kuti murume wangu aramba “small house” yake adzoka kwandiri** (I was just happy that my husband had dumped his “small house” and returned to me). Later he was struggling to walk and he didn’t have a wheelchair, so we started to share my wheelchair. We were happy for two years then he died of AIDS.*

As previously noted, a study carried out by Wazakili, Mpofu, and Devlieger (2006) in a South African township revealed that in some instances the desire of disabled people to be accepted and to be loved may supersede the importance of engaging in safe sexual practices. The above narrative brings to the fore an assertion made by Wazakili, Mpofu, and Devlieger (2006), which as previously mentioned, states that there is no guarantee that when people are informed of the risk of acquiring HIV, such people will make efforts to avoid such risks. “Whereas biomedical reasoning sees risk as something impersonal, linked to statistical inference and probability, holistic reasoning is personal and relational, situating the individual within the social context with all its constraints, as well as possibilities” (Haram 2005, p. 3). However, from a critical FDS perspective, Wilkerson (2011) questions traditional perspectives that put pressure on women to yearn for the very norms of womanhood that not only subordinate them but which also make them less human. The reality is that, as previously mentioned, the acquisition of a husband and settling down in marriage in the context of this study is a highly respected achievement (Zinanga 1996); participants may therefore attempt to achieve such “normalcy”, albeit engaging in unsafe sexual practices.

It is evident that almost all the participants are at a high risk of contracting HIV due to the repeated breakdown of their intimate partner relationships and GBV. It appears that whilst their openness in searching for love and belonging may illuminate their defiance of the asexuality stereotype and buttress their agency and bravery, it entangles them in a cycle where they hope to find true love from the intimate partners that they engage in sexual relations with and it seems that such an exchange rarely materialises. Tari who has albinism says:

A man can say, “Let’s have sex and I will marry you”, and then he just dumps me after sex. Some men lie that they are not married and I discover he is married when his wife comes to beat me up for loving her husband; it’s just not an easy life...

A study carried out in Kwazulu-Natal, South Africa, revealed that there is a general belief that disabled women are not at risk of contracting HIV (Hanass-Hancock, 2009b). Such beliefs are often fuelled by numerous myths that surround disability such as the belief that disabled people are asexual beings. Nevertheless, it appears that compared to their non-disabled counterparts, participants become more vulnerable to acquiring the HIV virus through engaging in multiple partner relationships as they struggle to acquire stable and reciprocal intimate partner relationships, in a context where the Christian church exacerbates such vulnerabilities. As highlighted in Chapter 5, Chipso recounts that as a professional Counsellor for disabled women she noted that some disabled women are taught to be submissive to their husbands at all costs in accordance with the Bible. In resonance with such an assertion, Mara, who has a spinal cord induced physical impairment, says:

*The church was praying for my disability and my husband and saying, “Heal Mara of disability and release Mara’s husband from bondage”. This prayer worked in the same way **inoita mushonga wekuNigeria unodzora varume kumba** (that the Nigerian medicine which brings errant husbands back home does). He came back and I started to have sex with my husband, knowing that God wants me to submit to him according to the Bible, so God will protect me from HIV. After all I am doing the right thing to have sex with my husband and not with a boyfriend so people cannot blame me.*

The above narrative reveals that the contextual interpretation of the Biblical concept of submission to husbands as articulated in the Bible, maybe a key driver of the spread of HIV.

It is evident that religion is powerful to the extent that religious beliefs may become more important than the risk of acquiring HIV. Mara's narrative illuminates a disabled woman's conviction that the Bible directs women to submit to their husbands as reflected in Christian literature; in Colossians 3 vs 18, the Bible says: "Wives, submit to your husbands..." (Biblica, Inc, 2011). Whilst such teachings may be common among all women, there is evidence that in interpreting such a scripture some participants may not censor it to suit their circumstances. Researchers have illuminated a gap between rational thinking and the definition of risky sexual behaviour (Haram, 2005; Wazakili, Mpofu, & Devlieger, 2006). The desire to achieve "normalcy" and to subsequently earn respectability by engaging in sexual relations with a husband and not a boyfriend in accordance with Biblical teaching becomes more significant than the risk of acquiring HIV. It appears that the vulnerability to HIV infection among participants may also be exacerbated by the use of vaginal products, as discussed below.

As discussed in Theme 1, the use of vaginal products may symbolise some form of feminine strategic power in circumstances where disabled women claim their agency to enhance eroticism in their heterosexual relations. However, such practices carry the risk of fuelling HIV infection, given that the practices discourage the use of condoms. Mako, who has epilepsy, says: *"When I use the products my vagina becomes too tight and I have wounds but the sex becomes painful for me but enjoyable for my boyfriend, we don't use condoms."* Protected sex would defeat the purpose of using the vaginal products which are meant to increase pleasure through conventional contact of the vagina and penis in coitus (Bagnol & Mariano, 2008b). In Mozambique, healthcare staff indicated possible negative health outcomes of using such products: inflammation and swelling of the vagina, uterus cancer, infections and increased exposure to STIs and HIV/AIDs infections due to lacerations on both the vagina and penis due to dry sex (Bagnol & Mariano, 2008a, 2008b). However, very little research, if any, has been undertaken to provide concrete evidence of the negative effects of the traditional approaches of modifying vaginal functioning, hence it would be premature to draw conclusions. The discussion of GBV under this second theme is closely linked to the third theme of matrimonial relationships, which I discuss below.

Theme 3: Matrimonial relationships

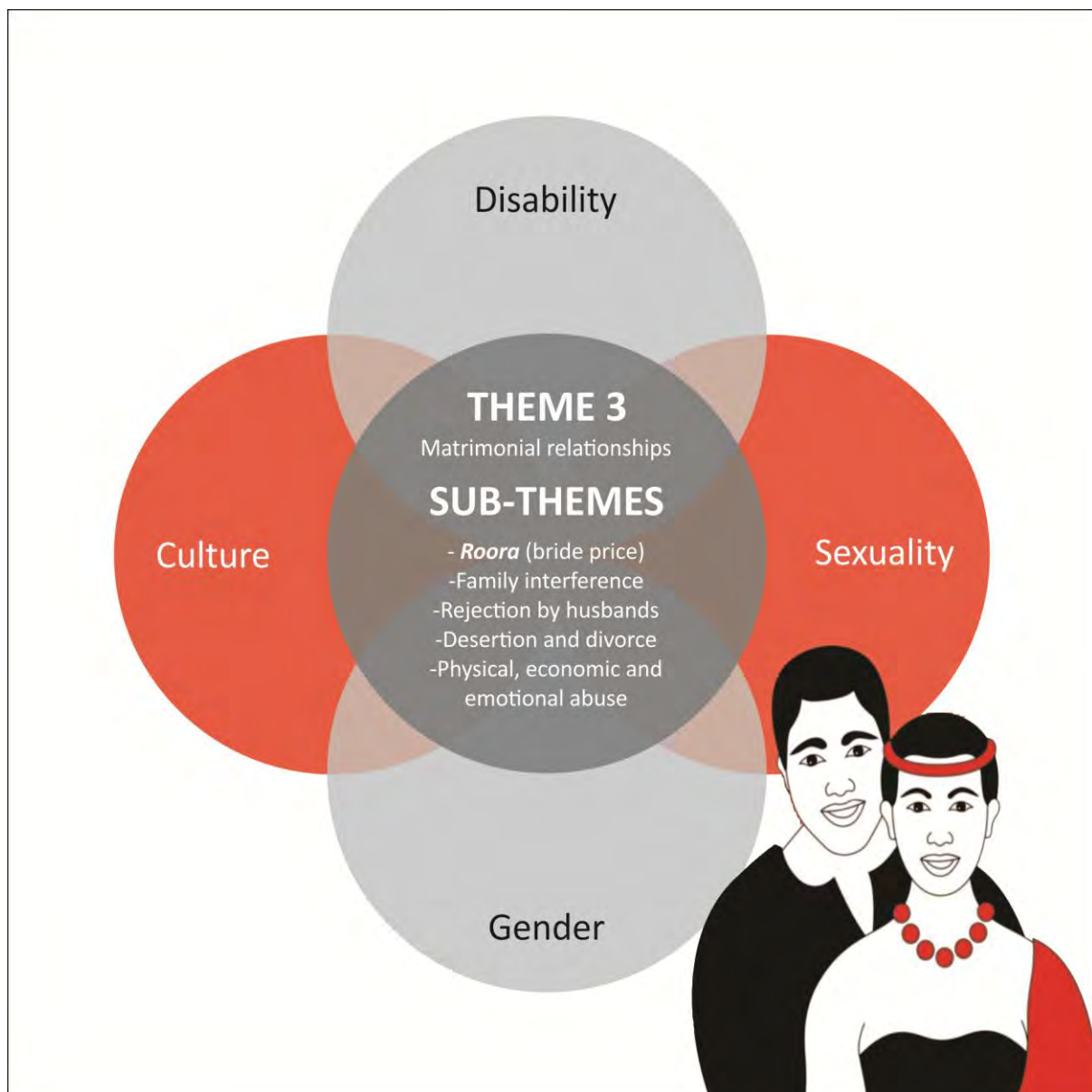


Figure 5: Matrimonial relationships

Figure 5 above indicates that the theme of matrimonial relationships is constituted by the sub-themes of: a) *roora* (bride price); b) family interference; c) rejection by husbands; d) desertion and divorce; and e) physical, economic and emotional abuse. The theme and its integral sub-themes illuminate the intersectionality of the experiences of sexuality of participants. I discuss the sub-theme of *roora* (bride price), below.

Roora (bride price)

There is strong evidence that some men who engage disabled women in intimate partner relationships are reluctant to fulfil the significant traditional practice of paying *roora* (the

bride price) for them. From the perspective of some participants such reluctance stems from the fact that some men regard disabled women as “damaged goods” who are not worth paying **roora** for. Mako, who has epilepsy, says: *“I just stayed with him for two years and we had a son, but he didn’t pay roora for me so I was not happy.”* As noted in Chapter 5, Danai, who has albinism, expressed dissatisfaction with the fact that her live-in boyfriend of 10 years, with whom she has two children, has not paid **roora** for her. However, Danai also stresses the fact that she believes she is better off deriving intimate satisfaction from the relationship than having no intimate relationship at all. In another example, Tamara, who has partial visual impairment, says: *“I have a son who is six years old with my boyfriend but he has not paid roora for me. I want him to pay.”*

Local literature reveals that **roora** (the bride price) still holds its significance in the Zimbabwean custom (Chigwedere, 1982; Chireshe & Chireshe, 2010), albeit the fact that with “modernity” some young men are now trivialising the practice (The Herald, 2015). **Roora** brings the family of the bride and that of the bridegroom together at a traditional ceremony which symbolises gratitude to the bride’s family for birthing and raising their daughter, who by virtue of the traditional marriage is expected to broaden her husband’s family by birthing children (Chireshe & Chireshe, 2010). Local media publications reveal a general belief among people in Zimbabwe that men who by-pass the fundamental African custom of paying **roora** are practising **manenji** (a bizarre act) (The Herald, 2015), which will ultimately bring misfortune upon their lives.

Whilst local media publications (The Herald, 2015) are pointing to the fact that it is young men who are trivialising the custom of **roora**, the findings of this study indicate that disability makes a difference; regardless of age, some men who cohabit with some participants and have fathered or not fathered children with the participants, tend to ignore the traditional practice on the grounds that the woman involved in the heterosexual union is disabled. For example, and as illuminated in Chapter 5, Tsitsi’s live in boyfriend, who in 2014 was 54 years old, reportedly saw no point in paying **roora** for Tsitsi who has a physical impairment. Such a situation could be interpreted to mean that impairment is foregrounded to frame a disabled woman’s experiences of sexuality, in a context where she is perceived as being unworthy of the honour of having the **roora** paid for her because she is disabled.

Engaging in sexual relations with a woman for whom a man has not paid **roora**, means that the man regards such a woman as one of a lesser value and therefore “...one of whiling up time – a kind of toy” (Chireshe & Chireshe, 2010, p. 216). However, on the other hand, some scholars have argued that the practice of paying **roora** contributes to the oppression of women who are then treated as objects that are purchased by men (Chabata, 2012) on the open market. Such a situation defeats the liberation of women of today, who from a feminist perspective are advocating for a voice, in a setting where the “cry” for gender equity becomes a voice of those “crying” in the wilderness where no one hears them. “Implicitly, if gender equality is an epitome of the feminist ‘paradise’ then the custom...is one of the roadblocks on the highway to this ‘paradise’” (Chireshe & Chireshe, 2010, p. 217), in a context where disability brings a difference to the podium, as discussed below.

From the above perspective, one can argue that by not having **roora** paid for them, disabled women are then able to evade the control of men which relegates those for whom **roora** is paid to a subordinate position where their voice is silenced and their capability to claim their agency is castrated. However, the findings of this study point to the prevalence of male domination in a patriarchal context where disabled women are relegated to a subordinate position to men, regardless of whether **roora** has been paid for the disabled women or not. Tari, who has albinism, says; “*My boyfriend bullies me around, he demands sex without condom but he did not even pay roora for me.*” In different examples, the narratives of Tsitsi and Danai in Chapter 5 are indicative of women who are in some ways subordinate to their male intimate partners, in spite of the fact that their live-in male intimate partners have not made an effort to pay **roora** for the women, to fulfil the traditional custom which takes various shades, as further discussed below.

From another perspective, **roora** is used as an excuse to offer a new wife to a man whose wife acquires impairment in the course of a marriage. As noted in Chapter 5, Chipo narrated that when she acquired a physical impairment her father felt that her husband (who had paid **roora** for Chipo) needed to acquire a non-disabled wife because Chipo was now “damaged goods.”. As previously noted, Chipo’s non-disabled sister was therefore offered to Chipo’s husband as a second wife. Such a scenario brings to the fore the FDS perspectives of the normate; the normate often assumes that disability erases all the other qualities of a human being, thereby reducing the complex being to a single social life attribute (Garland-Thomson, 1997). In this instance, Chipo’s impairment is foregrounded at the express exclusion of

Chipo's all other social life attributes such as sexuality and gender. Whilst local literature reveals that the payment of **roora** is regarded as some form of social stabiliser (Chireshe & Chireshe, 2010), the findings of this study reveal that disability disrupts such stability, in a scenario where disability intersects with gender and culture to undermine the experiences of sexuality of a disabled woman in heterosexual marriage.

There is evidence that although arranged marriages are not a common phenomenon in Zimbabwe, there is widespread family interference in intimate partner relationships. For example, Tari says:

My boyfriend's brother had a wife. That woman was a problem. She openly said 'babamunini mashayeyi kuroora musope anozozvara masope' (my husband's younger brother, what have you failed to find for you to marry an albino who is going to give birth to albinos) she has an evil spirit and she is a witch.

As discussed in Chapter 3, disability within the context of this study is associated with evil spirits, taboos and witchcraft (Mpofu & Harley, 2002). As such, men often experience immense cultural pressure to desist from marrying a disabled woman (Pasipanodya, 2013). However, it is interesting to note that in some cases families who oppose marital unions with disabled women may change their minds and end up accepting the disabled women depending on circumstances. For example, and as previously mentioned, Danai's boyfriend has not yet paid **roora** for her after 10 years of them living together. However, Danai narrated that she was later accepted by her boyfriend's family because of the economic assistance that she extends to that family, given the fact that she worked her way up from the dungeons of poverty to become a self-sustaining government primary school teacher who earns a regular income. From another angle, the payment of **roora** is also not a guarantee for a successful marriage as discussed under the sub-theme of rejection by husbands, below.

Rejection by husbands

All participants who acquired impairment after their husbands had paid **roora** for them at ceremonies, which symbolise the formalising of their traditional matrimonial unions, reported that they were rejected by their husbands when the women acquired impairment. For example, Mara says:

...With my spinal cord injury, I can only do one position of sex. I can't change, change or change. Also a spasm can come during sex and I can squeeze my husband with my legs and it takes a long time for him to separate his body from my legs. One day my spasm came and I pinned him on my body with my legs whilst he was on top of me having sex. So he had to wait until the spasm had gone, then my legs unfroze and he got off me. He shouted at me and said, "Ah! What kind of shit is this?" After that he ran away with a "small house".

Literature from the Global North states that women who acquire spinal cord injuries within the course of their marriages are more likely to get divorced, compared to those who marry after acquiring impairment (Basson, 1998). However, it appears that in the context of this study, men prefer to acquire "small houses" (mistresses) than to divorce. Mara says:

My husband took a "small house" so that he could have sex with her, but we have a marriage of Chapter 5:11 which does not allow a man to have more than one wife or to have "small houses", so I see that the marriage certificate does not work.

The findings of this study reveal that cultural values contribute towards stopping some reportedly unloving husbands from instituting divorce proceedings against their disabled wives. The objective of retaining disabled wives in matrimony is to guard against evoking the anger of the ancestors by divorcing the women, as exemplified by Chipó's narrative in Chapter 5. The disgruntlement of ancestors is undesirable because ancestors harbour the benevolent spirit which protects the family from all forms of possible harm (Mpofu & Harley, 2002), which includes illness, impairment or death. However, the irony of the matter is that the husband may live his life as if his disabled wife does not exist, as exemplified in Chipó's narrative in Chapter 5. Such a scenario represents what Thomas (2006, p. 182) calls "...psychosocial-emotional dimensions of disability...a form of disablism that works along psychological and emotional pathways." Thomas (2006) states that the result of such a kind of disablism is that disabled people are "...made to feel worthless, useless, of lesser value, unattractive, a burden" (p. 182). The findings of this study show that in some instances the husband may openly engage in intimate partner relationships with "small houses" with the full knowledge of his wife, thereby causing the woman intense emotional pain, as exemplified by Chipó's narrative in Chapter 5 and Mara's narrative, as quoted above, in a

context where the provisions of a formal and legal marriage become irrelevant in circumstances which are further discussed below.

The Marriage Act of Zimbabwe (Government of Zimbabwe, 1964) has been criticised by local legal experts as being defective, considering that it appears to recognise only one man one wife civil marriages, when the reality on the ground is different (Gonda, 2013). Men who marry under Chapter 5:11 are not allowed to marry more than one wife or to have a “small house”, but polygamous unions are allowed under Chapter 5:07 which permits one man to marry as many wives as he chooses to and each wife can have her own marriage certificate. However, the examples of Chipo and Mara indicate that they are legally married under Chapter 5:11 which prohibits more than one wife for each man, but it appears that their husbands and their families may use cultural ideologies to force disabled women to accept either a co-wife or a “small house”. It appears that a woman who acquires impairment in the course of her marriage loses her legal marital entitlements in a setting where gender, disability and culture intersect to frame her experiences of sexuality, as further discussed below.

All women who acquired impairment in the course of their marriages reported that their husbands and the families of the husbands made it clear that they despised the disabled women’s altered ability to fulfil the traditional feminine roles that are expected of the women in African society. A good African woman is one who carries the burdens of the family, works hard, grows vegetables, cleans and cooks for her husband among other things (Dangarembga, 1988), which may be difficult in the case of physical impairment. In a patriarchal society where women are subordinate to men, impairment further complicates femininity, resulting in the woman losing her entire status, only to be judged as completely useless (Boylan, 1991). Mara, who has a spinal cord induced physical impairment, says: *“My husband would not tell me what he was planning, he would just talk to his relatives, but you see even if I am disabled my brains are still working.”* In resonance with an assertion made by Thomas (2006), when such psycho-emotional dimensions of disablism manifest, disabled persons may find themselves having to perpetually deal with discriminatory responses in their interactions with others. However, linked to the subject of rejection by husbands, which I have discussed under this sub-theme, is the ultimate occurrence of desertion and divorce, which I discuss below.

Desertion and divorce

There is evidence that all participants who married disabled men were deserted by their husbands, who then opted to marry non-disabled women, in spite of a shared identity marker of disability with participants. For example, Saru says:

But we are all Deaf, but he went to South Africa and stopped writing letters. I wanted romance and I was not getting it, so everything was just useless. I went back to my mother's house and I heard he married a non-disabled woman.

It is apparent that in the example stated above, the social life attributes of disability and gender intersect to influence the experiences of sexuality of a disabled woman. Literature from the Global North indicates that some disabled women often choose disabled partners on the grounds that such relationships may offer them solidarity, friendship, and common values (Hershey, 2000). However, it is evident that in the context of this study, a shared identity marker of disability is not the only single social life attribute which determines the sustenance or failure of a marriage, given that disability intersects with other identity markers such as gender and culture to shape the experiences of sexuality of a disabled woman. However, it appears that even though some non-disabled men may make a decision to marry disabled women with the full knowledge that the women are disabled, such men may still later on abandon their disabled wives in preference of non-disabled women, as discussed below.

The above scenario is evident in the example of Mako, who married a non-disabled man after she had acquired epilepsy. Mako says: *"He dumped me at my mother's house whilst I was in epileptic absentia. When I got well I asked him why? Because when we married he said he did not mind epilepsy."* Global Northern literature indicates that marriages that are established after impairment stand a greater chance of experiencing both general and sexuality happiness (Basson, 1998). However, the findings of this study reveal that the acceptance of a woman's impairment by a male spouse at the onset of a marriage is not a guarantee for marital bliss or success. Such an outcome may be attributed to the tone of local media publications in Zimbabwe (Pasipanodya, 2013) which, as previously noted, reveal that men who may fall in love with disabled women are often castigated by their families and communities to the extent that they may end up abandoning their disabled spouses. It is evident that in such cases the social life attributes of gender, disability and culture intersect to influence the experiences of sexuality of participants. The subject of desertion and divorce

which I have discussed in this sub-theme is closely related to some aspects of the physical abuse that is perpetrated against disabled women by male intimate partners, as discussed below.

Physical abuse by intimate partners

The evidence of physical abuse that emerges in this study arises from Deaf participants and those who marry later on in their lives. There is strong evidence that participants who are Deaf are physically abused by their Deaf male intimate partners. For example, Rudo says: *“Me and my ex-husband are deaf, but when I fell pregnant he began to beat me up if I upset him in any way. People said you can’t beat up a pregnant woman and he said, ‘I don’t care’.”* In another example, Saru says:

...We are both Deaf but if I say “No!” to sex, he beats me up...he just waits for erection and if his erection comes he just enters. I was not allowed to touch his penis or other parts of his body. If I get close to him and want to try something new about sex, he would say, “Where did you learn that? So you are a prostitute”, and he beats me up. He would say, “I have finished sex with you, so now just get away from me.

The physical abuse perpetrated by Rudo and Saru’s Deaf husbands against their Deaf wives can be attributed to the assertion that most Deaf women marry Deaf men, who in most cases are as ill-prepared for adult functioning as their female spouses (Jacobs cited in Becker & Jauregui, 1985, p. 28). As such, Rudo’s and Saru’s ex-husbands, who are both Deaf, could have been suffering from a skewed conceptualisation of manhood, which in gendered terms dictates that men should be strong and domineering over their weak and passive wives. Such practices bring to the fore Wolfensburger’s perspectives of normalization which state that disabled people may seek to do what every other person does hence disabled men may beat up their partners as a way of proving their masculine aggression (cited in Shakespeare, 2000). It appears that the women may in turn accept such physical abuse on the grounds that even non-disabled women are also beaten up by their partners. However, Global Northern literature has indicated that those who survive violence often suffer malignant penalties in the form of longstanding psychological, social and physical consequences (Rosenberg, Butchart, Mercy, Narasimhan, Waters, & Marshall, 2006). Viewed from such a perspective, one may argue that whilst it may be true that Rudo lost her babies during childbirth due to the fact that healthcare staff was unable to speak sign language, there is a possibility that she may also

have lost her children as a consequence of complications that may have arisen from being beaten up by her husband during pregnancy.

The findings of this study reveal that disabled women who marry later on in their lives may believe that they do not have much of a choice but to accept abusive relationships. For example, Tatenda, who married for the first time at the age of 54, endured numerous incidences of physical abuse perpetrated by her husband. Tatenda says:

He was an alcoholic; he would beat me up and throw me around like a piece of paper. One day he threw me in the bush and I was full of thorns. He would hit me, and then say, "What happened to your face?". I say, "You hit me", and he says, "You are mad. I never hit you." One day I said to him, "Enough is enough, you choose between your beer and me".

Studies that have been carried out in the Global North reveal that disabled women who experience a delayed start to their sexual experience are likely to believe that they do not have much of a choice but to accept abusive relationships (Nosek et al., 2001). However, the findings of this study reveal that some disabled women who marry later on in life are not passive recipients of physical abuse. As exemplified by Tatenda's narrative above, she was able to claim her agency and to challenge her husband to make a choice between beer and herself. However, it is evident that the origin of the nature of abuse experienced by some participants in the context of this study may be attributed to normative gender roles and power relations within heteronormative practices. Below, I discuss the sub-theme of economic abuse which is one of the forms of abuse which is experienced by disabled women and which is closely related to the physical abuse which I have discussed in this section.

Economic abuse

There is strong evidence that all participants who acquired impairment during the course of their marriages were subjected to economic abuse by their non-disabled husbands. There is also evidence that all Deaf participants experienced spousal economic abuse. For example, Saru, who is Deaf, says: *"I saw that my husband was useless because he was beating me up and he was not giving me any money for support for me and our son. So I started to sell sweets and biscuits in **Kaguvi** street."* From the perspective of participants, such practices denigrate disabled women along the lines that they are not fit to receive spousal economic

support because they are disabled, in cases where disability, culture and gender intersect to exacerbate the marginalisation of disabled women. For example, Chipo's narrative in Chapter 5 reveals that when she acquired physical impairment due to spinal cord injury, her husband stopped advancing financial support to her. In another example, Mara's husband withdrew all the financial support that he used to give to Mara before she acquired physical impairment. Mara says:

When I got spinal cord injury, my husband stopped to buy food for me and our children. I use gloves for hygiene. I need a new catheter every two weeks, but urine bag I need new one every two days. So now imagine my husband would not give me any money. At times I got help from the church but you see they can't do that every day so I have infections. I get sick because I can't have money to buy the right things to use.

Studies that have been carried out in the Global North indicate that some impairments may result in the occurrence of additional impairments or other health related challenges, but such challenges can be prevented if the woman is educated about the manner in which she should prevent the problems (Hershey, 2000). However, it is clear that some participants may obtain such knowledge from local rehabilitation centres, but due to poverty, they may be unable to acquire the disability aids that are required to avoid health problems. For example, Mara says:

I was taught everything about gloves, catheter, urine bag and other things during the full year that I spent at St. Giles rehab centre after spinal cord injury, but it's hard to get things if you have no money. Now I sell used clothes at the gate there but I get very little money.

Devoid of her husband's economic support, Mara struggled to acquire assistive devices until she started to sell used clothes at the gate of her place of residence in one of the high density suburbs in Harare. However, in what appears to be a different kind of economic abuse, there is also evidence that some non-disabled men may cohabit with disabled women in heterosexual unions for as long as the men are being financially supported by the disabled women, as discussed below.

In Chapter 5, Tsitsi's narrative shows that she is the breadwinner in her approximately one year long intimate relationship with her 54-year-old unemployed boyfriend. There is a dearth of literature on non-disabled men who engage disabled women in intimate partner relationships and stay with the women for as long as the disabled women are supporting the non-disabled men financially. However, it is difficult to determine whether such men live with disabled women out of genuine love, or because it is a way through which the men sustain a living. Nevertheless, from the perspective of some participants, a disabled woman's ability to earn income provides her with a competitive edge in acquiring a long term intimate partner albeit a poor unemployed dependent partner, in a context where a disabled woman is competing with non-disabled women for male intimate partners. Below, I present the sub-theme of emotional abuse which is another form of abuse which was reported by some participants.

Emotional abuse

Most participants reported that they bore emotional abuse perpetrated against them by their husbands. As noted in Chapter 5, Chipso illuminated experiences in which, although she slept in the same bed with her once loving husband, the husband would wrap himself in a separate blanket to avoid any form of contact with her after she had acquired a physical impairment. In another example, Mara says:

I was having sex with my husband and his body lay on my urine bag by mistake and it broke, leaking all the urine that it had collected. He jumped out of bed as if he had been bitten by a snake and he said, "Jesus! What kind of shit is this? I should just send you back to your parents".

Literature from the Global North has indicated that disabled women experience various forms of emotional abuse which may include being shouted at and threats of desertion (Saxton et al., 2001). In resonance with such an assertion, Mara's husband yelled at her and threatened to send her back to her parents after her urine bag had leaked through no fault of hers, in a situation where gender and disability intersect to shape a disabled woman's experiences of sexuality. Social practices that destabilise the emotional welfare of disabled people are described as those that are inclusive of "...being hurt by the reactions of other people, being made to feel worthless and unattractive, and have their roots in the negative attitudes and prejudices about disabled people within society" (Reeve, 2002, p. 495). According to Thomas

(2006), such psycho-emotional dimensions of disability represent a kind of disablism which functions both within and upon the framework of the realities of gender. It is therefore clear that by being insensitive to Mara when Mara's urine bag had leaked; her husband was hurting Mara's emotional well-being. Such emotional abuse is further exemplified by another incident, as narrated by Mara:

*He acquired a "small house" whilst I was still in rehab. When I came out he told me that he had found a woman **anogona bonde** (who is good in bed). I was very hurt but his relatives were saying in our culture a man cannot suffer because his wife is disabled because a man needs to have sex all the time.*

It is evident that disabled women are generally perceived as sub-standard, asexual beings whose emotions are either non-existent or perhaps are not worth being sensitive to. Whilst local literature (Chingandu 2005), points to the fact that "small house" relationships are hidden from the "big house" (first wife), the findings of this study indicate that disability makes a difference. In apparent practices of emotional abuse, men whose wives acquire impairment do not make an effort to hide their "small house" relationships from their wives, as in the example of Mara's narrative above. The men reportedly feel that they are justified to acquire "small houses" because their wives have impairments and therefore they are not "real" women. One can say that in such cases, the idea of the body classifies people in a scenario where the disabled are relegated to locations where they become subordinate and vulnerable "objects", in practices where norms, perspectives and ideologies frame bodies that have impairments (Malmberg, 2009). However, the different forms of abuse (physical, economic, emotional) that I have discussed under this third theme may be exacerbated by the silences that surround issues of sexuality as discussed under the fourth and last theme below.

Theme 4: Silences surrounding issues of sexuality

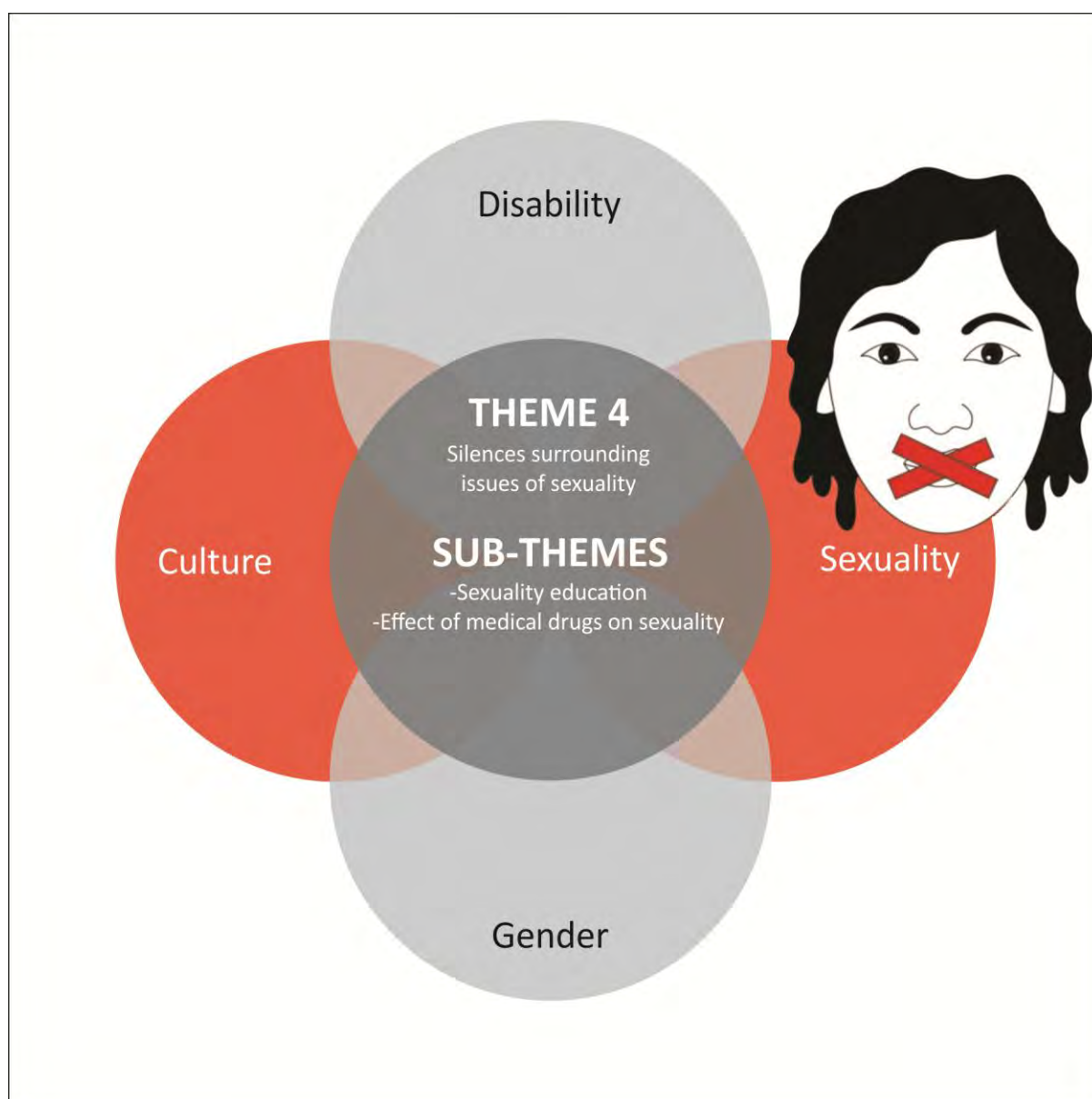


Figure 6: Silences surrounding issues of sexuality

Figure 6 above, illustrates that the theme of the silences that surround issues of sexuality is embedded with the sub-themes of: a) sexuality education; and b) effect of medical drugs on sexuality. The theme and its integral sub-themes reflect the intersectional nature of the experiences of sexuality of participants. I discuss the sub-theme of sexuality education below.

Sexuality education

There is strong evidence that participants who have congenital impairment and those who acquire impairment in early childhood (between the ages of 1-7) are isolated from sexuality education. For example, Nyasha and Saru narrated that they struggled to manage their

menstruation periods because their families had not educated them about the practice. For example, Nyasha, who is visually impaired, says:

My mother did not teach me about menstruation so I suffered. I could not keep track of dates and I was shy when I spoilt my dress with menstruation blood. The teacher cut pieces of cloth from bed linen and said when I use one I should wash it and so on. So I started to put a cloth in my underpants everyday even without menstruation because I was afraid to spoil my dress. I just thought its better that way than for people to say, "Look at that stupid blind girl who is moving around with menstruation".

Saru, who is Deaf, was shocked when for the first time she saw her menstruation blood. She says:

I was shocked to see blood coming out of my body. I said, "God, what is this?" No one had told me about menstruation. Not even my grandmother...I was in school so the other girls said, "Use a piece of cloth". I started to use a piece of blanket, then when it gets soaked with blood I wash it and reuse it again. But the bleeding was not good for me so I hated it...

The above narratives exemplify the repercussions of a lack of sexuality education on the part of disabled girls. The UNFPA (2015) affirms the impartation of sexuality education as a human right and works with governments to achieve the same. However, other scholars (Makinwa-Adebusoye & Tiemoko, 2007; Ndanga, 2007) note that sexuality education is a highly contested area which is fraught with power struggles and controversy because of the divergent perspectives that come with it. Whilst proponents of sexuality education argue that it is a necessary exercise of equipping people with skills and knowledge to foster healthy and responsible sexuality, critiques argue that the best thing is to keep the subject hidden from people (Makinwa-Adebusoye & Tiemoko, 2007). In relation to disability, the belief is that talking about sexuality will result in the awakening of disabled people's sexual feelings. However, proponents argue that there is no such thing as "awakening" feelings, because the feelings are already present in all human beings (Mirfin-Veitch, 2003). If that is the case, then sweeping the subject of sexuality education under the carpet is tantamount to undermining the well-being of all human beings, including that of disabled girls and women.

The findings of this study indicate that parents, and in particular mothers, are reportedly reluctant to discuss issues of sexual maturation with participants. As highlighted in Chapter 5, Danai narrated that she learnt about the use of cotton wool during her menstrual cycle from her friends because her mother maintained silence on the subject. Such a scenario can be attributed to the fact that parents often struggle to embrace the sexuality of their daughters whom they perceive to have “damaged” bodies and minds (Begum, 1992). From a critical FDS perspective, Hall (2011) states that such a practice signals an adult mind-set which hopes to confine disabled girls to infinite girlhood, free from the sexual growth “trauma” of menstruating and developing breasts as exemplified by the story of the Ashley treatment which I previously discussed.

All disabled women who acquired impairment after adolescence reported that they had received traditional sexuality education within their families and communities. Such education is similar to that which has been noted in Kenya by Kiiru (2007); the education includes sexual initiation practices and the articulation of taboos that relate to the regulation of sexual behaviour, thereby helping a girl to internalise sexual norms that are valued within her society. For example, Mako learnt to elongate her labia in the village, at the age of 10, before she acquired epilepsy at the age of 16:

We used to go like a group of girls to the river and the grandmothers would teach us to pull our labia. After some days they would inspect our vaginas to see if we were doing well. But they said we should not have sex with boyfriends but we should wait to use our pulled labia until we get married.

All participants who acquired impairment before adolescence or who have congenital impairment reported that they were excluded from formal traditional systems of sexuality education, in cases where gender, disability and culture intersected to create their exclusion. For example, Rudo, who became deaf at the age of two, learnt to elongate her labia from friends in school because she had been isolated by her family from such traditional sexuality education, on the grounds that she is deaf. “*In my family they did not tell me about it, so I learnt it in Deaf school. A girl who was taught by her grandmother to pull also taught me and the other girls in school.*” People can learn about sex through school programmes, friends and parents (Irwin, n.d.), but it may not be easy for a disabled girl to make friends, particularly a girl who does not get an opportunity to attend school, because disability

stereotypes may prevent her from experiencing normal interactions with other girls. Learning about sexuality may also be difficult for girls and women who live in rehabilitation institutions, as discussed below.

All participants who live in institutions indicated that they are deprived of formal sexuality education as professionals prefer to maintain silence on the subject. For example, Gamu, who has intellectual impairment, illuminates her ignorance of sexuality issues by blaming her period pain on the physical location of the rehabilitation institution where she stays. *“This place is not good with blood...I want you to take me with you when you go, because I am tired of this pain of blood which I get because I live here.”* It is evident that the rehabilitation staff may be using the archaic argument that has historically been applied to people with psychiatric impairments: “...if we don’t talk about it, we won’t put ideas into their heads and they will not show any interest in sex...” (Andrews & Studd, 2005, p. 117). Critics have dismissed such an argument as absolute nonsense, on the basis that all human beings have sexual drives. Although such sexual drives may differ from person to person, they still need to be acknowledged in healthcare. However, as previously indicated and from a FDS viewpoint, Wilkerson (2011) states that “othered” groups often confront coercion, limitations, and punishments and, they are often denied access to significant information that is relevant to their sexuality. The narrative of Gamu depicts a young woman who is devoid of appropriate sexuality vocabulary and education. Saru says:

I want knowledge about sexuality things, but everyone is silent from the time I was young. Now I hear that all men in Zimbabwe are being circumcised. For us Deaf women we don’t know why we should choose a man who was circumcised or not...I want to know sexuality things that are good or bad just like other people, so that I can make the right choices, but no one talks to deaf people about sexuality.

The above narrative illuminates the fact that Saru is challenging the myth that she is an asexual being who does not deserve any information on issues of sexuality. The silences that surround the issues of sexuality education, as discussed under this sub-theme, are also prevalent in healthcare delivery systems, thereby impacting on the sexuality of disabled women in relation to impairment related medical drugs, as discussed below.

Effect of medical drugs on the sexuality of disabled women

There is strong evidence that impairment related medical drugs may alter the nature of the experiences of sexuality of disabled women, but healthcare staff maintains silence on such issues. Mayita, who has a psychosocial impairment, refers to her intimate partner who also has a psychosocial impairment and says:

Even though I take a higher dose than him, I notice that he will just sleep, but as for me I don't sleep...I take nine tablets, and after that I want lots of sex; he takes just one tablet but he goes off to sleep and he doesn't want sex, but in hospital we are afraid to talk about this problem because the nurses think we don't have sex, so they just give us tablets and injection and we go quietly, but we have a problem of our sex.

There is a paucity of literature on the effects of impairment related medical drugs on the sexuality of disabled men and disabled women in African contexts. However, a study carried out in Canada reveals that issues such as high or low libido and the timing of sexual activity are some of the aspects that are worth tabling for discussion in the healthcare of disabled women (Basson, 1998). The contextual silences that are surrounding issues of sexuality resonate with the assertion made by Wilkerson (2011) from a FDS perspective, which states that the medical fraternity uses its power to prescribe the inappropriateness of the sexuality of disabled women. Disabled women are therefore afraid to initiate discussions on issues of sexuality with healthcare staff for fear of being reprimanded. A study carried out in the UK revealed that healthcare centres may engage in disempowering practices, which subsequently undermine the well-being of disabled women (Thomas 1997). Considering that in the context of this study, healthcare staff is made up of the same people who are part of the society which associates disability with taboos, witchcraft and spirits, such attitudes may perpetuate into the formal healthcare delivery system thereby seeking to repress the sexuality of disabled women, as discussed below.

Repression of sexuality

There is strong evidence that engaging in intimate partner relationships in some rehabilitation institutions is a punishable offence. For example, Gamu and Nyarai feel that their boyfriends, who also have intellectual impairments, love them a lot, but they have to keep their relationships a secret, for fear of being reprimanded by institutional authorities. Gamu says: *"I know he loves me much, but I hope you will keep your promise that you will not tell them*

that I have a boyfriend, because they will punish me.” As noted in Chapter 5, Nyarai explained that she runs the risk of being punished by being denied food if rehabilitation staff gets to know that she has a boyfriend. Chappell and Wirz (2003) argue that other than just simply receiving rehabilitation services, there are other complex variables that can affect a disabled person’s life satisfaction and well-being. Drawing from examples put forward by Chappell and Wirz (2003), I argue that the lack of sexual support in rehabilitation institutions contributes to the detriment of the overall well-being of participants. However, the policing of the sexuality of participants in rehabilitation institutions may arise from various factors, some of which are discussed below.

Literature indicates that within an African context, feminine sexual activity that is not carried out within the confines of a marriage and for purposes of reproduction is branded as deviant sexual activity which may attract heavy penalties (Makinwa-Adebusoye & Tiemoko, 2007). It then follows that if institutions define sexuality as sex between a man and a woman, then the prohibition of relationships of sexuality may be attributed to such perspectives. The examples of Gamu and Nyarai above, interrogate the effectiveness of the United Nations Convention on the Rights of Persons with Disabilities, (CRPD) (United Nations, 2008) and the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (United Nations, 1979) in protecting the rights of disabled girls and women. As previously mentioned, it is evident that the recognition of rights and the realisation of such rights are two different things that may not be simultaneously achieved.

All participants who live in institutions reported that they are constantly subjected to very close supervision. For example, Gamu says: *“We are not allowed to go to the house of boys and the boys are not allowed to come to us, because they fear we can have love...”* The rule reflected in this narrative can be attributed to the observation that out-dated Global Northern designed rehabilitation models are often exported to Global Southern countries with the support of international specialists and donors (McConkey & O’Toole, 1995). However, local budgets may not be adequate to hire appropriately trained personnel to carry out the relevant tasks. Based on such a school of thought, one can argue that the efforts made by staff to suppress and silence the sexuality of Nyarai and Gamu, is perhaps because the staff has not been trained in the area of disability and sexuality. From another angle, the repression could be attributed to the fact that authorities could be fearful of the sexuality of disabled people; hence they would rather keep the myth of disabled people’s asexuality alive. Or it may be

that staff tries to protect disabled people to ensure that they are sexually safe. Although the Zimbabwe Disabled Persons Act (Government of Zimbabwe, 1992) is silent on sexual relations of disabled people, Warner, Pitts, Crawford, Serfaty, Prabhakaran, and Amin (2004) note that in some countries such as the UK, healthcare providers have a legal obligation to protect people with psychosocial impairments from sexual abuse.

If one were to borrow the above perspectives from the UK, one may argue that institutional staff is responsible for preventing sexual activity among the disabled because such staff is held responsible if disabled people under institutional care are to acquire for example, an STI or if they fall pregnant (Warner et al., 2004). However, in other countries, restrictive sexual policies in institutions are interpreted to mean a serious violation of the disabled people's human rights. One may state that the strict relationship rules and regulations that are promulgated in rehabilitation institutions in the context of this study are meant to deny privacy to disabled women and to thwart the sexuality of disabled women, thereby violating their human rights. Whichever way, considering the fact that sexuality forms a central part of being human and it is a basic right for all people (Gomez, 2012; Nganda, 2007), perhaps the focus of institutional staff in the context of this study should not be to suppress the sexuality of disabled women but to adopt practices that are outlined below.

In resonance with the assertion made by Warner, Pitts, Crawford, Serfaty, Prabhakaran, and Amin (2004), the focus of institutional staff should be to seek to draw a line between adults who consent to having sex and those who are forced to do so and in either case to deal with the resultant challenges. For example, the experiences of sex in the chicken run, as illuminated in Nyarai's narrative in Chapter 5, point at rushed, unprotected sexual encounters in unsuitable places which might pose serious health risks to both Nyarai and her boyfriend. In addition, the practice of having sex in the chicken run to counter institutional restrictions undermines the dignity of disabled women who have the same sexual rights as non-disabled men and women. As such, Warner, Pitts, Crawford, Serfaty, Prabhakaran, and Amin (2004) urge mental healthcare institutions to come to terms with the reality that whether they like it or not, sexual activity does occur at such institutions hence the provision of condoms and contraceptives and advice among other things is necessary.

Conclusion

In this chapter, I have presented the themes that emerged from a cross case-analysis of the 16 narratives that represent the entire data set of this study. As noted in the introductory section of this chapter, the themes reveal the complex intersection of disability, sexuality, gender, and culture and in some instances class and poverty, in a patriarchal context where participants are constantly negotiating power relations as they dynamically engage in heterosexual intimate partner relationships. Such an intersection facilitates the vulnerability of disabled women to inequitable, unsafe and coercive sexual practices that increase their vulnerability to GBV and HIV infection, in a context where silences that are surrounding issues of sexuality are detrimental to the well-being of disabled women. I present the findings of this study in the next chapter.

CHAPTER SEVEN

DISCUSSION OF FINDINGS

In this chapter, I present the discussion of findings which is embedded with the third level of analysis. I remind the reader that I began by presenting my first level of analysis through robust examples of four biographic narratives in Chapter five. At the second level and in Chapter 6, I sought to make meaning out of all the biographic narratives that make up the entire data set of this study by presenting and analysing themes that arose from such narratives. In this seventh chapter, I present the discussion of findings which is intertwined with the third level of analysis which, due to its interpretative nature, seeks to deepen our understanding of the experiences of sexuality of disabled women in Zimbabwe by focusing on what participants meant when they said what they said, including that which was unspoken or indirect. Such interpretations are among other things meant to contribute towards the building of theoretical formulations in disability and sexuality that are rooted in the African context.

I remind the reader that the central research question for this study is: How do disabled women in Zimbabwe experience their sexuality? The findings of this study illuminate the fact that disabled women are not passive recipients of disability and sexuality stereotypes, but they claim their agency and construct their own understanding of what it means to be sexual, thereby creating opportunities for themselves in the area of sexuality. In addition, disabled women attach value to heterosexual marriage in an effort to conform to heterosexual norms that are prevalent in the context of this study; such norms are framed around patriarchal gender relations, around which the women seek to earn moral respectability. Furthermore, culture, disability, and normative gender roles and power relations intersect to create the vulnerability of disabled women to inequitable, unsafe and coercive sexual practices that increase their vulnerability to GBV and HIV infection. Such vulnerability is also exacerbated by the intersection of disability, culture and the myth of asexuality which creates a lack of sexuality education among participants. I present the first key finding below.

Key Finding 1

Disabled women are not passive recipients of disability and sexuality stereotypes. They engage in dynamic processes of practising various aspects of their agency, thereby creating opportunities for themselves in the area of sexuality.

The findings of this study indicate that participants are not passive recipients of disability and sexuality stereotypes. They assert and express their sexuality in ways that challenge the dominant, restrictive and ableist constructions of sexuality. As noted in Chapter 6, all participants reported that they are sexually active and they desire to love and to belong, thereby engaging in heteronormative relationships and making conscious choices of lovers and modes of addressing their sexuality. Through engaging in traditional sexual practices such as sexual initiation and using vaginal products, some participants reportedly “prospered” in enhancing eroticism in their experiences of sexuality in a context where disabled women compete with non-disabled women for the attention of male intimate partners. Such practices interrogate the views of the mainstream feminist discourse which have generally viewed disabled women as women with individual “tragedies” that require private personal attention, charity or care (Price, 2011). However, one may argue that participants may be attempting to prove that their bodies and their sexuality are what Beckett (2004) calls “un-problematic”, in a setting where the negative conceptualisation of disability undermines the gender and sexuality of disabled women.

In the context of this study, most participants illuminate a contradiction in which they say that on the one hand participants are regarded as useless asexual beings and on the other hand and as noted in Chapter 6, participants are regarded as sexually useful in traditional and miraculous religious healing practices that seek to “cure” men of HIV, epilepsy as well as to enable the men to get rich. It is evident that as noted in Chapter 2, the idea of the body classifies people in a scenario where disabled people are relegated to locations where they become subordinate and vulnerable “objects” in practices where norms, perspectives and ideologies frame bodies that have impairments (Malmberg 2009). However, whilst participants have reported the oppression that is characteristic of their experiences of sexuality, they also depict a sense of power, agency and hope, which in some cases extended to a boast about the way in which the women negotiate the challenges they confront and the privileges they create for themselves in the zone of sexuality. A question therefore arises:

how does a disabled woman's gender affiliation, culture and class intersect to enhance or to restrict her experiences of sexuality within an African context? Tensions emerge between oppression and pleasure and between male domination and the participants' strategic power, in a context where in some instances participants refer to men folk as oppressors whilst at the same time they regard such men as people who occupy positions of importance in their lives. Borrowing words from Dunne cited in Beckett (2004), I metaphorically state that participants report their experiences of sexuality with a tone which resembles practices of disabled women who from their own perspective are "sleeping with the enemy".

Some participants who have had the experience of marriage, reported that they engaged in extra-marital relationships with married men, as a way of asserting their sexuality, demonstrating their power and gaining admiration for themselves and their experiences of sexuality, albeit in a guarded way. From a FDS perspective, I argue that such practices challenge the dominant non-disabled ideologies about sexuality. Furthermore, such relationships are indicative of disabled women who are making efforts to overcome oppression as opposed to living with oppression, in a context where the women reportedly feel that their sexuality is grossly misunderstood. I do not mean to say that I condone unfaithfulness, but I deduce that the extra-marital relationships contradict the views of feminists in the Global North, who as noted by Hooks (1981), highlight that Black women are "good little women" who have the strength to live with oppression but not to overcome it; such a contradiction runs along the same vein as the one discussed below.

The narratives of some unmarried participants depict a tension between the African traditional and religious organisations that seek to prohibit sex outside of marriage and the desire for disabled women to address their sexuality within heterosexual marriage. Participants reported that they face difficulties in acquiring marital partners due to the traditional conceptualisation of disability which associates disability with taboos, spirits and witchcraft and which results in men facing immense pressure to desist from marrying disabled women. The scenario reverberates with one of the key arguments of FDS which queries the inability of society to embrace disability as human diversity, thereby relegating disability to a category of inferiority within ableist societies and environments (Chouinard, 1997; Garland-Thomson, 2005). Whichever way, participants are left with no choice but to break out of the traditional marital norms and to search for self-governance outside of societal

expectations, thereby engaging in sexual relations outside of the revered heterosexual marriage set-up.

Describing a typical African community Ogbujah (2007) states that, the major expectation of African tradition on the part of individuals is “total compliance” with explicit values and practices that prevail in their community. By defiantly addressing their sexuality elsewhere other than in the “sacred” institution of heterosexual marriage, participants concur with the proclamation that the expression of one’s sexuality should not be regarded as a luxury which can be likened to the acquisition of a luxurious top of the range car (Romano, 1978) or as a personal hobby such as that of collecting stamps (Wilkerson 2011), but as postulated by Gomez (2012) it is a necessity which determines the physical and mental well-being of all human beings. The voice of participants therefore challenges the social model of disability for neglecting the subject of sexuality and yet it is evident that whilst disability may be a strong social life attribute which is capable of edifying others (Shakespeare 1996) sexuality may be more significant to some people than disability. Closely linked to this first key finding is the second key finding which indicates the value that is attached to heterosexual marriage by participants as discussed below.

Key Finding 2

Disabled women value heterosexual marriage in a context where the women are constantly trying to conform to heteronormative ideas of sexuality in an effort to gain respectability, within a context which esteems heterosexuality and denigrates different sexual orientations.

All unmarried participants, including those who previously experienced abusive marriages, reported that they aspire to marry or to remarry, in a situation where participants appear to believe that marriage would normalise them. It is evident that in trying to construct a normative identity, participants make perpetual efforts to “fit in” with the sexual norms that prevail in a context where heterosexuality is foregrounded as the only point of entry into the terrain of normal adulthood sexuality. As noted in Chapter 3 and Chapter 6, local literature indicates that the acquisition of a husband and the sustenance of a marriage is regarded as a highly respectable feminine achievement in Zimbabwe (Zinanga, 1996). Disabled people may choose to either resist or to cooperate with practices that seek to normalise their bodies (Shakespeare, 2006) and in this context the latter process seems to be at work. However, the

question of why participants encounter challenges in acquiring and sustaining marriages is significant, but it appears that the question does not have a clear cut obvious answer, as further discussed below.

Perspectives from the Global North indicate that disabled women are regarded as women who are lacking in ideal appearance and capability to render physical and emotional support to the male spouse (Fine and Asch 1997). In addition, Garland-Thomson (2005) states that disabled women are usually regarded as unattractive beings, who are unfit to be parents. In the context of this study and as previously discussed participants assign the difficulties they encounter in acquiring marital partners to traditional beliefs that associate disability with taboos, spirits and witchcraft. Participants argue that they are not harmful human beings but they are victims of the sins that were committed by their forefathers or other paternal relatives resulting in participants having either congenital or acquired impairments that ultimately lead to their struggle in acquiring marital partners. From a FDS perspective Garland-Thomson (1997) argues that there is no standard way of defining what it means to be 'normal' and whilst some people may epitomise themselves as 'normal' human beings, the reality is that very few if any people can actually fit into the mould of the normate. However, the findings of this study indicate that the contextual traditional conceptualisation of disability, results in participants being relegated to the position of social problems or burdens that no potential marital partner or his family would want to associate with in marriage. From a Global Northern viewpoint, one way of dealing with the challenge is to draw on Wolfensburger's concept of normalisation (cited in Shakespeare 2000), thereby advocating for the integration of disabled women in the mainstream of sexuality as further discussed below.

The integration of disabled women into the mainstream of sexuality, allows the women to interact with everyone else, thereby broadening their chances of being understood and ultimately acquiring heterosexual marriages (Shakespeare 2000). However, from a FDS perspective, Garland-Thomson (1997) argues that whilst the concept of normalisation may be useful, the practice does not recognise the fact that disabled women may prefer to separate themselves from the eyes of the oppressor; in other words the eyes of non-disabled people. However, it is striking to note that the findings of this study reveal that in spite of the fact that disabled men and disabled women share a common identity marker of disability, disabled men may also form part of the oppressive normate system which formulates a negative

identity of disabled women on the grounds that the women have impairments. Such practices contradict the findings of a study carried out in the US, which indicated that a common impairment plays a significant role in influencing a couple's development of a close intimate relationship, compared to engaging in an intimate relationship with a non-disabled partner (Crawford & Ostrove, 2003). It is evident that in the context of this study and in resonance with the assertion made by Meekosha and Dowse (1997b), disability is both a gendered and feminized phenomenon. Some participants argue that they think they are better off with non-disabled partners than disabled partners and some report that they would be happier with disabled partners on the grounds that they share a common identity marker of impairment; a one-size-fits-all approach would therefore not work.

Literature reveals that some women in the Global North are choosing to settle for non-traditional sexual lifestyles within contexts where marriage is regarded as a social option (Asch and Fine 1997). However, one can argue that the engagement of participants in non-traditional sexual lifestyles as discussed under the previous key finding may not be purely by choice; but it may also be framed by default, given the negative constructions of disability which result in men desisting from marrying disabled women. Whichever way, by yearning for heterosexual marriage, participants argue that they are capable of meeting the traditional expectations of a marital set up which holds the prospects of earning the women respectability. From a viewpoint of FDS, Garland-Thomson (1997) notes that the normate is so powerful that people are perpetually trying to fit into the normate's mould and metaphorically, in the same way that Cinderellas's step-sisters attempted to squeeze their feet into her slipper. It is evident that acquiring a heterosexual marriage, coupled with reproduction within such a union becomes a status symbol in a context where local society esteems heterosexuality whilst it denigrates different sexual orientations as further discussed below.

As noted in Chapters 1, 2, 3, 4 and 6, most African people in Zimbabwe denounce different sexual orientations other than heterosexuality and the constitution of Zimbabwe also prohibits same sex marriages (Government of Zimbabwe 2013). In Chapter 2, I illuminated the FDS example of the narrative of two Deaf lesbians in the US who intended to have a Deaf child (Kafer 2011). Whilst such a narrative may represent a resistance to non-disabled heterosexuality, it is evident that the narratives of participants are devoid of any language of different sexual orientations in a context where heterosexuality appears to be the only

acceptable, respectable and compulsory sexual sphere. In resonance with an assertion made by Beckett (2004), it appears that in the context of this study, one may not enter the zone of normal adulthood sexuality, unless one is heterosexual; hence failure to be part of such a sexual sphere becomes an ‘abnormality’. One is therefore left to wonder about the contextual location of an African woman who is both disabled and a lesbian; chances are that such a woman is totally invisible and devoid of any kind of social privilege. I discuss the third key finding below, which shows the vulnerability of disabled women to inequitable, unsafe and coercive sexual practices that increase the vulnerability of participants to GBV and HIV infection.

Key Finding 3

The complex intersection of culture, disability and normative gender roles and power relations within heteronormative relationships facilitate the vulnerability of disabled women to inequitable, unsafe and coercive sexual practices that increase their vulnerability to GBV and HIV infection both inside and outside of the national healthcare delivery system.

The findings of this study indicate that the traditional conceptualisation of disability results in participants and their families accepting any mode of treatment which promises to “cure” participants of impairment. As noted in Chapter 6, modes of treatment may include prescriptions of penis/vagina coitus between the traditional healer and the religious prophet, within practices that exacerbate the vulnerability of participants to GBV and HIV infection. Similar to the perspectives of Meekosha (1998), I would say that such practices appear to be valorised by families on the pretext of seeking vital medical treatment, and yet the objective is to normalize the “abnormal” feminine body so that it fits in with the perspectives of the normate. That is not to say participants lack personal agency, but it is to say that participants may yield to suspicious traditional and religious “curing” methods as they battle to achieve conformity with bodily ideals that promise to allocate them space and acknowledgement on the contextual landscape of sexuality. I side with the FDS perspective of Erevelles (2011) and state that such practices challenge FDS to go beyond the criticism of the category “woman” and to engage with “difference” on the continuum of identity markers such as race, ethnicity, class, nationality and sexuality. Perhaps it is time for FDS to create space for the voice of disabled Black women in the Global South, and particularly in Africa to be heard, thereby

enabling a wholesome success of the transformative FDS, which may include some African practices such as those discussed below.

Traditional healers have historically been known to successfully treat the people of Africa including in Zimbabwe for generations, using a combination of rituals and herbs (Chavhunduka, 1998; Dandurad & White, n.d.). One can therefore argue that traditional healers who reportedly detain disabled women and coerce them into unsafe sexual practices in the name of “treatment” and “love” are likely to be fake unregistered practitioners. However, it is difficult to draw such a conclusion, considering that none of the participants reported to have seen or asked to see the healer’s registration certificate as awarded by the Traditional Medical Practitioners Council, under the Ministry of Health and Child Care, which is responsible for registering traditional healers and religious prophets in Zimbabwe (Meya, 2014). It appears that traditional healers and religious prophets are regarded as sacred beings who possess supernatural ancestral powers and Godly spirits respectively; people are therefore fearful of querying the healer’s or prophet’s registration status or prowess, as further discussed below.

The power of traditional healers as highlighted above, can be likened to the power of Western medical practice, which as noted by some FDS scholars (Wilkerson, 2011), has become extremely powerful to the extent that it goes beyond prescribing medicinal treatment to tell people how to live their lives. As noted in Chapter 2, Wilkerson states that the Global Northern medical discourse is rarely questioned, because the general belief is that medical proclamations are absolutely objective. However, the medical practice in the context of this study stretches beyond contemporary science to include *n’anga* (traditional healers) *nemaporofita* (and religious prophets) who offer spiritual explications as to why the impairment would have occurred in the first place as well as a “cure” thereof. Contrary to such practice is the FDS perspective of Hall (2011), who states that the focus of FDS is not on curing impairment but on aspects that can enhance people’s ways of living as well as efforts that can be made to identify and critique the issues that make the life of a disabled person unworthy of living. However, the findings of this study indicate that decisions pertaining to impairment are usually taken at family level within a context of a broad array of kinship relations who may approve of any mode of treatment including that of a sexual nature which may exacerbate the vulnerability of participants to HIV, in a desperate bid to “cure” impairment. I concur with the assertion made by McCarthy (1999) and argue that there is no

need for people in society to try to manage the bodies of disabled women so that they fit into constricted norms, but the point is to respect and value difference.

The findings of this study also reveal that an oppressed participant who may be at risk of experiencing GBV and acquiring HIV may still be unwilling to challenge or to “flee” from marital difficulties, alongside a traditional belief that the ability of a woman to bear hardships earns such a woman respect and good repute. In the context of this study, women are traditionally regarded as the overall bearers of the burdens of the family and the ability of a woman to shoulder such burdens, including sexual burdens, is expected to earn the woman respect (Dangarembga, 1988). All participants who had the experience of abusive marriages highlighted their reluctance to file for divorce for fear of tarnishing family and kinship relations; divorce therefore appears to only take place in cases where it is instituted by the male spouse. However, some participants narrated that whilst social benefits may accrue to non-disabled women who endure abusive marriages, participants do not seem to gain any form of respectability for similar behaviour. In such instances, disability makes a difference as family and community members reportedly argue that participants have no choice but to endure abusive relationships because they are lucky to have married in the first place because no one wants them. Whilst as noted in Chapter 6, most participants reported experiences of physical, emotional and economic abuse as perpetrated by their intimate partners, none of the participants attempted to draw assistance from the provisions of the Zimbabwe Domestic Violence Act (Government of Zimbabwe, 2006) which acknowledges domestic violence perpetrated against disabled people, including that which takes place within marriages. The finding therefore suggests a need to raise awareness of the legal provisions of the Domestic Violence Act among participants. I discuss the fourth and last key finding below.

Key Finding 4

Disability, culture and the myth of asexuality intersect to create misinformation, silence and indifference towards the sexual maturation of disabled girls and a lack of sexuality education for disabled girls and women.

The findings of this study reveal that most families dealt with the subject of the sexual maturation of participants privately, without seeking to draw on any community or institutional support. The most reported family responses to the sexual maturation of

participants (particularly those with congenital impairment or those who acquired impairment before adolescence) include misinformation, total silence and indifference. Responses that have been recorded in some Global Northern countries include that of the Ashley treatment (Hall, 2011), which demonstrates that parents may actively draw on medical expertise to stop the sexual maturation of girls. As noted in Chapter 2, Ashley's parents justified the treatment on the grounds that Ashley's non-development of features that mark womanhood on her body would be less stressful for her; critics argued that the treatment represented a form of gendered oppression. However, in variance with such an approach and as mentioned above participants reported adult responses which are embedded with traditional beliefs and practices that result in total silence, adult indifference and misinformation about the sexual growth of participants.

Most participants reported that they did not receive any form of sexuality education from their parents and in particular their mothers. Local literature reveals that in the Zimbabwean context it is generally regarded as unAfrican for parents to openly discuss issues of sexuality with their children (Mungwini & Matereke, 2010). From pre-colonial times, the responsibility of imparting sexuality education to young women in Zimbabwe has always rested with *vanatete hanzvadzi dzababa* (aunts/father's sisters). However, the arrival of modernism and the resultant increase in rural-urban migration in post-colonial Zimbabwe has seen a breakdown of the family lineage bonds (Banda, 2012). As families move to different parts of the nation and even beyond the borders of the country in search of economic opportunities, it has become difficult for aunts to play their role in the upbringing of young women and in particular in the nurturing of the young women's sexual development. The findings of this study indicate that disability makes a difference because with or without *vanatete* disabled girls and women are usually isolated from such education in cases where gender, disability and the myth of asexuality intersect to create such exclusion. However, from a FDS perspective Garland-Thomson (2005) states that as FDS moves towards inclusion from exclusion, the approach makes an effort to rescue silenced voices and misrepresented experiences, thereby facilitating the accommodation of bodies instead of the condemnation of them.

Local literature indicates that the government of Zimbabwe introduced sex education/life skills training in schools in the year 2000 under the banner of Guidance and Counselling (Banda, 2012; Mafiki, 2011). Such a change is largely progressive and it signals a move

towards a more sexuality conscious society. However, sexuality education in schools follows a particular restricted syllabus whose format may restrict the impartation of knowledge that is tailor made to suit the unique needs of each pupil (Banda, 2012). All participants who attended school after the introduction of sex education in high schools reported that staff in the special schools they attended was either silent or indifferent to the subject of sexuality. From a FDS perspective, Wilkerson (2011) asserts that sexuality holds severe consequences for those whose bodies are regarded as unsuitable to fit into constricted perspectives of the norm in relation to sexuality and “able-bodiedness” among other social life attributes. In the context of this study, norms, perspectives and ideologies appear to frame bodies that have impairments to deny disabled girls sexuality education, albeit the inadequacy of the syllabus, as discussed below.

Assuming that participants had received sex education in special schools, the most they could have obtained would have probably been abstinence-based knowledge only. That is so, because as articulated by Banda (2012), the sex education syllabus in Zimbabwean schools thus far is designed to focus on abstinence only and it does not include the complexities of sexuality. Whilst teaching abstinence may prevent STIs, HIV or unwanted pregnancies, the findings of this study point to a need to introduce an all-encompassing sexuality education syllabus in all schools including special schools, so that disabled young adults may learn to make their own informed decisions regarding issues of sexuality. The point is that sexuality encompasses much more than abstinence to include other dimensions such as menstruation, desire, pleasure, emotion, intimacy, eroticism, romance, reproduction and companionship (Makinwa-Adebusoye & Tiemoko, 2007). It therefore follows that a sex education syllabus which does not encompass all elements of sexuality may actually do the students a disservice in the same way that it would in rehabilitation and healthcare institutions, as discussed below.

As noted in Chapter 6, it is evident that rehabilitation institutions and healthcare centres do not provide participants with any form of sexuality education or support. Most participants reported that they are hesitant to discuss issues of sexuality with institutional staff for fear of being reprimanded as participants are aware that their sexuality is regarded as inappropriate. However, Thomas and Curtis (1997, p. 209) argue that “The cards are already stacked against disabled women and it is sad indeed if...staff become part of the disabling social environment which such women have to negotiate.” The irony of the matter is that, as noted by Wilkerson (2011) and from a FDS point of view, the medical discourse is rarely questioned because

once a bodily status has been certified by the medical fraternity as being sub-standard, people seldom query such certification.

Conclusion

In this chapter, I have presented the discussion of findings which is embedded with the third level of analysis which builds from the second level of analysis which I presented in Chapter 6. It is clear that the experiences of sexuality of participants are not static, but they change over time in accordance with the roles that the women choose to play and the nature of the relationships they choose to engage in, as they regulate the increase and decrease of the challenges which they confront. There is evidence that the experiences of sexuality of participants vary in accordance with the way in which the social life attributes of disability, gender and culture, among other identity markers, intersect in their life worlds at any one time to frame such experiences. As disabled women's experiences of sexuality persistently evolve, the women constantly distinguish themselves with multiple identities in a setting where time and location combine to influence the disabled women's experiences of sexuality. I outline the theoretical and methodological reflections and contributions of this study in the next chapter.

CHAPTER EIGHT

THEORETICAL/METHODOLOGICAL REFLECTIONS

In this chapter I return to the purpose of this study which was to explore within an African context the experiences of sexuality of disabled women in Zimbabwe. I remind the reader that the research question for this study is: How do disabled women in Zimbabwe experience their sexuality? I reflect on the theoretical and methodological choices that I made in seeking to answer the research question. Through the use of a unique combination of research methods this study has made a contribution towards the development of indigenous theoretical formulations of disability and sexuality that are rooted in the African context.

8.1 Reflections on conceptual framework

As I reflect on this narrative inquiry which sought to explore the experiences of sexuality of disabled women in Zimbabwe, I confirm that the theoretical choices that I made in creating the conceptual framework that has guided this study under an overarching critical FDS lens were the most appropriate for the study. Below, I examine the suitability of each category of the conceptual framework.

8.1.1 Feminist Disability Studies (FDS)

As highlighted in Chapter 2, FDS seek to understand disability from a gender point of view, following the mainstream feminist marginalisation of disabled women's experiences (Meekosha, 2004). I was therefore able to use the critical notions of FDS to explore the experiences of sexuality of participants from a gender perspective, albeit in a context where gender intersects with other social life attributes such as culture and disability to frame such experiences. In addition, by drawing on the perspectives of FDS which are amenable to different sexual orientations, I also ensured that this study evades a discriminatory

deportment by being open to disabled women of all sexual orientations, in spite of the fact that all participants turned out to be heterosexual.

As noted in Chapter 2 and Chapter 6, a key argument of FDS is that disability is a social construction of “Other” by an ableist society which is not receptive of human differences but which regards disability as inferiority (Garland-Thomson, 2005; Chouinard, 1997). Such an argument was useful in analysing the contextual standpoint of participants regarding their sexuality and disability. However, FDS has been criticised by Ereveless (2011) for formulating a disabled identity which assumes that such an identity is not part of social, economic and historical contexts. I therefore mitigated the risk of ignoring such contexts by weaving in colonial/post-colonial, economic and socio-cultural perspectives in the analysis of data.

Whilst I have used the excellent FDS theoretical formulations which have been undertaken thus far, I argue that most of such visible leading works of FDS exclude perspectives from the Global South, particularly from Africa in a scenario which, if described in the words of Hamilton (2014), points at the practice of “leaving others out”. As discussed in Chapter 2, such a situation marginalises the viewpoints of theorists and researchers in Global Southern contexts and it suppresses the voice of disabled women including those of non-normative sexual orientations, particularly in Africa. In resonance with the assertion made by Mohanty (1988) about women in general, I state specifically that the deafening silence that encompasses the experiences of sexuality of disabled African women coupled with the need to build international linkages of disabled women’s political struggles, results in this study being both a novelty and a necessity.

I do not claim to be providing a supreme template of the ways in which FDS should assimilate the experiences of sexuality of disabled women in Africa. However, I argue that the groundbreaking nature of this study means that it symbolizes preliminary steps towards the formulation of what I call African Feminist Disability Studies (AFDS), which may in due course be more broadened and nuanced and which I present later on in schematic form in Section 9.1.6. Although I concur with Lewis (2013) that the success of any theoretical formulations may be judged by their ability to travel across different locations, I also agree with Amory (1997) that it is important to situate the development of theoretical formulations within the context of their construction. I therefore call upon African disability and feminist

scholars to play an active role in the development of AFDS so as to develop not only African scholarship but to also provide the tools that are required for the gradual development of the original, leading and transformative FDS, to enable such formulations to stretch beyond their initial locus. Below, I reflect on FDS perspectives of sexuality, power and the body which I used as part of the conceptual framework of this study.

8.1.2 FDS perspectives of sexuality, power and the body

The critical FDS perspectives on power, sexuality and the body have been helpful in illuminating the concept of the normate, which represents a construction of an identity by those who consider themselves to be “normal” enough in relation to their bodily features and capital (Garland-Thomson, 1997). I drew the example of the Ashley medical treatment (Hall, 2011) to demonstrate the extent to which the normate can control the sexuality and sexual development of disabled girls and women. However, I argue for a contextual AFDS theoretical lens, which could perhaps allow a more in-depth examination of the local normate’s perspectives and their implications on the sexuality of disabled girls and women, including in medical practice, as highlighted below.

As discussed in Chapter 2, the power of medicine lies in building statistical measures against which all human beings could be judged, thereby representing official processes of disciplining and controlling the body so that it maintains a certain standard of “normalcy” (Wilkerson, 2011). Such FDS perspectives have played a key role in the analysis of the interaction of disabled women in Zimbabwe with particularly contemporary medical centres. However, the Global Northern FDS notions of medicine may not be wholly relevant to the threefold approach to healthcare which is prevalent in the context of this study and which stretches beyond the contemporary scientific approach to include *n’anga* (traditional healers), *nemaporofita* (and religious prophets). Perhaps an overarching AFDS conceptual lens would have enhanced an exploration of the traditional and religious belief systems and contextual kinship relations that appear to have a strong bearing on healthcare choices in the context of this study.

From an FDS perspective (Wilkerson, 2011) states that disabled women who live in institutions are likely to experience a loss of their sexual agency due to a lack of privacy which prevails in residential institutions. By using such a FDS viewpoint among others, I was

able to explore the experiences of sexuality of some participants who live in rehabilitation institutions in Zimbabwe. Whilst the kind of oppression, marginalisation and isolation of disabled women which takes place in local institutions may bear a resemblance with that experienced in institutions in the Global North, I argue that the nature of the professional ethic, oppressive practices and reasons and outcomes of such practices and the kinds of intervention that could be required may differ in accordance with context. The situation therefore calls for an analysis which draws from AFDS so as to provide an in-depth contextual examination of the impact of transferring Global Northern concepts to a Global Southern context, on the experiences of sexuality of disabled women who live in local institutions.

As pointed out by Hall (2011) disability is an offshoot of power relations in which the body, and bodily differences and normalization are key in the analysis of all kinds of oppression. By drawing on FDS notions of power and the body I was able to provide an analysis of power relations that influence the experiences of sexuality of disabled women in Zimbabwe. The analysis demonstrated that, as illuminated by Foucault (1976), power is not all about dominance but power functions on people's own bodies and at micro levels of people's daily lives, in simultaneity with desire and knowledge. However, the analysis in this study extended the notion of power/knowledge to include that which is created by local cultural practices and not just power/knowledge which is generated by modern science. Perhaps the traditional perspectives of power/knowledge could have been better analysed through AFDS, so as to use an indigenous conceptual lens to further explore the impact of traditional beliefs on the experiences of sexuality of disabled women in Zimbabwe. However, closely linked to FDS perspectives of power, sexuality and the body which I have reflected on in this section, is my use of FDS viewpoints of intersectionality; a model which forms part of the conceptual framework which I made use of in this study and which I reflect on below.

8.1.3 FDS perspectives of intersectionality

The critical perspectives of FDS recognise that disability is closely inter-connected with other identity markers such as race, gender, sexuality and class (Syracuse University, n.d.; Garland-Thomson, 2005). I therefore used such a standpoint to illuminate the intersectional nature of the experiences of sexuality of disabled women in Zimbabwe. Whilst the concept of intersectionality arose from Black feminists in the US who were primarily concerned with

issues of gender, race and class, (Meekosha & Shuttleworth, 2009), the findings of this study introduce additional social life attributes to the local discourse: culture, sexuality, disability, poverty and nationality. That is not to say that I intend to assume an additive, one-plus-one approach which adds one social life attribute to the other (Sims, 2009; Bateson cited in Sims, 2009), but it is to say that I acknowledge the simultaneous interaction of the various social life attributes in shaping the experiences of sexuality of participants. However, the additional but intersecting social life attributes were made possible by what critiques call the ambiguity and open-endedness of intersectionality (Davis, 2008) and yet it is such vagueness and infiniteness that permits the exploration of an endless collection of intersecting modes of difference.

Through a discovery process, intersectionality brought to this study an awareness of the reality that the experiences of sexuality of disabled women are more complex and contradictory than what I had anticipated before embarking on the study. However, I took heed of the advice proffered by Sims (2009) and made an effort to ensure that the various social life attributes that emerge from the narratives of participants and that highlight the intersectional nature of the disabled women's experiences of sexuality are not marginalised. However, that is not to say that I claim to have included all social life attributes and all facets and variations of intersections in the analysis; but similar to an assertion made by Davis (2008), I am aware of the fact that perhaps there could be other intersectional dimensions that I have not been able to explore. Nevertheless, the attention that I pay to power relations and difference within the intersectional experiences of sexuality of disabled women enhances the analysis of this study.

The Global Northern feminist discourse has been criticised for universalising women, resulting in a lack of awareness of the diversity of the experiences of women in the Global South (Harding, 1986). The belief that women are a homogenous group with similar aspirations and interests, in spite of their location, culture, race or class, is fallacious (Mohanty, 1988). The same author critiqued the homogenous construction of a monolithic "Third World" woman and argued that such an approach is likely to freeze the "Third World" woman into an object. In a similar vein, this study has used an intersectional model to argue against a universal definition of woman which, as postulated by Nnaemeka (1998) and Oyewumi (2003), assumes that all women are the same and that they share similar narratives of lived experiences and oppression.

By drawing on intersectionality, this thesis has highlighted the various ways in which disabled women negotiate contextual power relations in an effort to assert their sexuality. Intersectionality has also illuminated the fact that disabled women are not total victims of oppression but they may also challenge, resist and undermine power relations at different turning points of their experiences of sexuality. Below, I reflect on the appropriateness of drawing on FDS perspectives of the social model of disability as a tool of analysis of the experiences of sexuality of disabled women in Zimbabwe.

8.1.4 FDS perspectives of the social model of disability

The social model of disability concurs with the critical viewpoints of FDS which do not focus on curing impairment but on embracing disability as a form of difference and ensuring the participation of disabled people in all facets of social life (Garland-Thomson, 2005; Shakespeare, 2000). Such viewpoints have been useful in examining the perpetual search for a “cure” for impairment by disabled women and their families, through using traditional and “miraculous” religious healing approaches. In spite of the fact that it is a British born model, by drawing on the social model of disability, I was able to analyse the extent to which the model is applicable in the African context, thereby embracing some of its tenets, rejecting some of the tenets and making suggestions for improvement, on the grounds that experiences of disability and sexuality differ in accordance with context.

By using FDS perspectives of the social model of disability, the voices of participants in this study query the masculine structure of the social model which ignores the concerns of women, thereby silencing the voice of disabled women and decreasing the visibility of disabled women in disability theory. In addition, the voices of participants also interrogate the social model of disability for neglecting the subject of sexuality, and yet it is evident that sexuality forms a core part of being human (Gomez, 2012) and it is of greatest concern to disabled women. A model which claims to shape disabled people’s experiences and to make them masters of their own destiny should sufficiently attend to the main concerns of all people (Lloyd, 2001), thereby providing an all-encompassing tool of analysis for the experiences of sexuality of all disabled people.

By drawing on the FDS viewpoints of the social model of disability as an analytical tool, I was able to illuminate the fact that by being gender insensitive, the social model does not

create space for disabled women, let alone their experiences of sexuality. In addition, the model over-emphasises an identity which is predominantly framed around the social life attribute of disability. Yet, the reality is that a person's life world cannot be wholly framed and understood by using a single characteristic of his or her identity (Hardy-Fanta, 2011). The findings of this study have indicated that disability intersects with other identity markers such as sexuality, gender, culture, religion, age, class and sexual orientation, albeit the nonattendance of the social model of disability to such social life attributes. I therefore suggest that the social model should present disabled people as intersectional people, thereby avoiding the generalisation of disability across nations as well as evading the chanting of a disability discourse which is underpinned by purely Western ideologies. The risk of the status quo is that any traditional definitions of disability may be reduced to what Robinson-Pant (2004) calls mere "cultural beliefs", which may not be taken seriously in disability theory. However, by directing civil rights legislation which prohibits discrimination on the grounds of impairment, the social model of disability advocates for the realisation of human rights (Thomas, 2006; Winter, 2003), which I discuss below.

8.1.5 Human rights

In my construction of the conceptual framework that I used to guide this study, I opted for an overarching critical FDS lens as opposed to a human rights framework. On reflection, I realise that such a decision was appropriate, given the fact that the human rights approach tends to prioritise single and stand-alone issues such as, for example, gender or disability; thereby deterring an in-depth exploration of the intersectional, multi-layered and multidimensional nature of the experiences of sexuality of participants. An overarching human rights lens would have also made it difficult for me to explore the kinship relationships which influence the experiences of sexuality of participants, given the nature of the human rights approach which, as postulated by Meekosha (2011), is framed around Western ideologies of individualism. That is not to say I discredit the relevance of human rights perspectives in the analysis of the experiences of sexuality of disabled women in Zimbabwe, but it is to say that I acknowledge the significance of human rights by drawing on FDS perspectives of the intersectional model, the social model of disability and my specific analytical use of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2006), the United Nations Convention on the Elimination of all forms of Discrimination against Women (CEDAW) (United Nations, 1979) and some local

legal instruments that cover subjects which include marriage, domestic violence and traditional medical practice.

Intersectionality reveals and transforms the interwoven functioning of oppression and power; through its transformative power, intersectionality can deconstruct and dismantle systems of oppression and power, thereby advancing the realisation of human rights for all human beings (Tomlinson, 2015). By drawing on FDS perspectives of the social model of disability I acknowledge the progressiveness of the social model in the passing of legislation which prohibits discrimination on the grounds of impairment, (Thomas, 2006; Tomlinson, 2015; Winter, 2003). However, such a human rights thrust of the social model demands appropriate interpretation and enforcement of the law if at all the laws are to be meaningful (Winter, 2003), in different contexts. The scenario is exemplified by the fact that all participants in this study indicated a non-awareness of the almost decade long existence of the Domestic Violence Act (Government of Zimbabwe, 2006) and its provisions.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2006) and the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (United Nations, 1979) are international human rights instruments that are relevant to this study and which have both been ratified by the Government of Zimbabwe. I drew on some provisions of such international legal instruments in order to examine the contextual attainability of human rights that participants are entitled to in the areas of disability and sexuality. However, I realised that similar to an assertion made by Izugbara and Undie (2008) conflict seems to reign between international legal instruments and some African customary practices. For example, Article 16 of the CRPD (United Nations, 2008) calls for the protection of disabled girls and disabled women against all forms of GBV and to ensure the availability of GBV recovery programmes, and yet the findings of this study reveal that at family level, local tradition permits a rapist to marry the victim in order to make the rape right. It appears that until such conflict is resolved disabled girls and disabled women may continue to be at the mercy of harmful sexual practices.

In summing up my reflections on the conceptual framework that I have used in this study, I remind the reader that due to a paucity of Global Southern theories and in particular African theories that are relevant to this study, the theoretical concepts that are embedded in this study's conceptual framework emanate from the Global North. However, I take cognisance of

the fact that the economic, social, political and historical realities in the Global North are different from those in the Global South. As such, I do not intend to follow in the footsteps of international development experts, who try to speed up the development of Global Southern countries by uncritically imposing Global Northern development theories in developing nations (Soetan, 2001). It is for that reason that I have suggested the development of “home grown” AFDS theoretical formulations, which represent a conceptual lens which arises from the inductive and deductive analysis of the data which I generated in this study, and which I present below.

8.1.6 Theoretical formulations of African Feminist Disability Studies (AFDS)

In this section I present AFDS theoretical formulations which arise from the findings of this study. An in-depth discussion of such formulations is beyond the scope of this study, hence I borrow practice from Davis (2008), and state that “...successful theories are successful precisely because they do not settle matters once and for all; they open them up for further discussion and inquiry” (p. 77). I therefore present the AFDS framework in schematic form in Table 4 below, alongside a belief that such a framework can be deepened and broadened in due course.

Table 4: Theoretical formulations of African Feminist Disability Studies (AFDS)

Category	Sub-category
1. Traditional conceptualisation of disability	<ul style="list-style-type: none"> • Breaking traditional taboos • Supernatural spirits • Witchcraft
2. Threefold approach to treatment and rehabilitation	<ul style="list-style-type: none"> • Traditional healers • Religious prophets • Contemporary health care
3. Value attached to sexuality	<ul style="list-style-type: none"> • Dynamic engagement in intimate partner relationships • Dominance of heterosexuality/different sexual orientations as a White man's disease • Traditional practices of sexual initiation/enhancing eroticism through vaginal modification
4. GBV and the resultant health outcomes	<ul style="list-style-type: none"> • GBV in treatment (modern/traditional/religious) • Power relations • Health outcomes of GBV
5. Agency and oppression	<ul style="list-style-type: none"> • Claiming agency and overcoming oppression • Individuality and communality • Silences surrounding issues of sexuality
6. Human rights	<ul style="list-style-type: none"> • International human rights instruments • Functionality in African contexts

The above framework is meant to lay a foundation for the development of AFDS thereby opening the door for future important work in feminist disability studies to be carried out. It would be futile to undermine indigenous ways of understanding impairment or to dismiss traditional knowledge as mere superstition or illogical thinking (Meekosha, 2011). An African theoretical understanding of disability and its integral threefold approach to treatment and rehabilitation is necessary in bringing the theoretical analysis of the experiences of disability and sexuality of Black, disabled African women closer to home. That is not to say that I do not recognise the significance of international cooperation, which encourages people across the globe to work together in unity. However, it is to acknowledge the fact that different societies have different ways of conceptualising disability and sexuality and unless such ways are interpreted with empathy and are clearly understood, it may be difficult for the conditions of disabled men and disabled women in the Global South, and particularly in African countries, to be improved. I mention both genders because although this study has explored the experiences of sexuality of disabled women, the focus of AFDS should not be on disabled women alone, but in line with the original FDS and as stated by Garland-Thomson (2002), it should encompass every one, thereby acknowledging the fact that disability has the potential to touch every individual and every family at any given time.

AFDS is also likely to permit a more precise and indigenous explanation of the aspects of African culture that influence disabled women to desire heterosexual relationships at all costs, albeit the fact that such relationships appear to relegate the women to sites of inferiority and subordination. In addition, AFDS theoretical formulations of GBV, HIV, agency and oppression are likely to enhance a contextual analysis of the power relations that characterise the experiences of sexuality of disabled people within a patriarchal context of communalism. In line with an assertion made by Sa'ar (2005), AFDS therefore holds the promise to address the tensions that exist between what appears to be disabled women's cooperation with patriarchy and the women's tactfulness in creating advantages or opportunities for themselves in the arena of sexuality, thereby offering both passive and active resistance. In addition, AFDS may also begin to, among other things, examine the reasons why disabled women do not pursue the legal rights that are guaranteed to them by both local and international legal instruments and the tensions that exist between such instruments and African culture.

By suggesting the above AFDS theoretical formulations, I do not mean to say that the overarching FDS lens that I have used in this study has not been analytically valuable, or to say that all local traditions are beneficial to the experiences of sexuality of disabled women in Zimbabwe. But I do mean to acknowledge the intellectual and cultural history and knowledge production of the Global South, particularly that which is rooted in the African context. In addition, I argue that indigenous theoretical or conceptual frameworks that take into consideration local historical, economic and cultural experiences are critical in bringing FDS closer to the nature of non-Western societies and the experiences of sexuality of disabled women in such contexts. In any case, "... intersectionality welcomed the margins to the table of theory making...by suggesting that experience could be the ground of theory making" (Lewis, 2013, p. 873). However, I take cognisance of the fact that theoretical or conceptual propositions and creations are closely linked to research data; I therefore reflect on the methodology that I used to generate data for this study.

8.2 Reflections on methodology

In this section I reflect on the appropriateness of the narrative methodology under an overarching qualitative research design which I used in this study and I state that such an approach was the most appropriate for the study. Through their narratives, participants have answered the question posed by Spivak (1988): "Can the Subaltern Speak?", evidently so – in

this study the voice of disabled women is heard, as the women explicitly narrate their experiences of sexuality. Participants have therefore challenged the myth that those who are located at the periphery of society are unable to take part in the creation of knowledge in academic circles or are not available to contribute towards theory formulation (Canagarajah, 1996; Dhunpath & Samuel, 2009). The experiences of sexuality that participants explicitly illuminate in this study make a significant contribution to the creation of academic knowledge by filling in a blank spot of knowledge regarding disabled women's interpretations and experiences of sexuality in Zimbabwe, which may not be similar to those experienced by disabled women in other contexts.

The narrative approach is a way through which experience can be studied and understood (Clandinin & Caine, 2008). In resonance with such an assertion the narrative approach has allowed this study to develop a contextual and intimate study of disabled women's experiences of sexuality over time. The study has sought to make meaning out of such experiences through conversation, dialogue and the researcher's ongoing participation in the life worlds of the disabled women. The close attention that the narrative methodology pays to experience as well as its orientation towards relational and ethical engagement has added to its appropriateness for the study of the experiences of sexuality of disabled women in Zimbabwe.

As noted in Chapter 1, most published literature on the topic of this study has been constructed from hearsay and second-hand narratives in studies which draw from the perspectives of parents, service providers and advocates, without any consultation of the relevant women (Dotson et al., 2003). African scholars such as Achebe (2000) have described those who recount experiences on behalf of others as people who have "absolute power over narrative" (p. 17); hence they can orchestrate stories in any manner which they like. The BNIM approach to data generation therefore proved to be appropriate in the sense that BNIM's structure permits the participant to shape their own story and its structure and to take as long as they want to narrate the story (Wengraf, 2013). It is remarkable to note that participants themselves appreciated the BNIM method of interviewing, and expressed their appreciation at the end of each interview when I asked them if they had anything else to say. For example, Rudo, who is Deaf, said:

Your topic of research is nice, and the method of interview is the No. 1 method. It's my first time to be interviewed that way. I like that you give me a lot of time to talk everything. Also you just let me say anything I want, without you saying that I am wrong, so I was able to relax. In some interviews the interviewer will say, "Don't say that", or he can say, "You are going off topic". When he says that I get confused and I feel stupid.

Nyasha who is visually impaired says;

I like your interview because you gave me information in Braille, other researchers they don't do that. Your interview is very good, it has given me a lot of time to talk about what I want and it also talks about sexuality because a lot of people are afraid to talk about sexuality. Other interviewers, they are always in a hurry, they just come and say; "now can you sit down Nyasha" and they start to ask me questions. I just give them the short answers which they want and they go, because they are not interested in my life. Also they don't take time to explain to me what their research is about, so when they leave, I just say "God help me" let me them go.

Whilst the aim of the BNIM principle which directs minimal control by the researcher is to empower participants (Wengraf, 2013) it is striking to note that participants acknowledge such empowerment in their own words. For example, Chipso, who has a spinal cord induced physical impairment, says:

Your topic of research is very important to me. I see that you think you have just come to interview me but you don't know that you have come to educate and to empower me. Your interview method has taught me that I have a story to tell and it helped me to see a full picture of my own life, which I had not seen in all the 54 years that I have lived on this earth. Right now, I am thinking of writing a book about my sexuality so people can learn about how disability can "kill" a woman's sexuality...

Through its focus on drawing narratives of past experiences instead of just eliciting the present circumstances, BNIM facilitates the discovery and expression of hidden and often dormant perspectives, customs and counter-narratives that relate to different times in the past (Wengraf, 2013). For example, Rudo says:

You see now I am 50 years old but your interview has helped me to remember my nickname of “mucus girl” in primary boarding school when I was six years old. From the time I became Deaf at five years old, mucus was coming out of my nose, even the traditional healer could not stop it.

The BNIM principle in Sub-session 2 is to only ask questions about issues that were raised in Sub-session 1, in the order in which they were raised and using words that were used by the narrator (Jones, 2006; Wengraf, 2013). The aim is to prevent breaking the participants’ gestalt and ultimately spoiling the research, whilst excavating additional story through asking Particular Incident Narrative (PIN) seeking questions. Rudo who is Deaf says:

I also like your interview because we take a break and we have drinks then you interview for the second time, and you ask questions about what we discussed the first time. In this second time, I see that I am able to tell you other things that I had forgotten to tell you the first time. With other interviews, there is no second time, so even if I forget to tell them something, they are already gone. I think they just go and write whatever, but I know in my heart that I have told them very little, because I can see that all they want is to get their questions answered quickly and they go; they don’t give me time like you do.

In appreciation of Sub-session 2, Nyasha who is visually impaired says;

I like that you ask me questions from what I have told you about my life the first time. It helps me to check that you were truly listening; because with some researchers there is no way of knowing whether they are truly listening or not. It’s a problem, especially for some of us who are blind and we cannot see the researcher. I worry that maybe the researcher is thinking that this is just a silly blind woman, how do I know, when I can’t even see the expression on the researcher’s face.

Reflecting on the performance of the BNIM interview, Saru says:

With other methods, they talk about boring topics and they give us questionnaires, and they say, “Answer YES!” or “NO!”. They say “Talking is not allowed”. But you

see I love to talk and I can talk to those who don't know sign language if there is an interpreter...I think these questionnaire guys are lazy, they don't want to find an interpreter so they just say questionnaire is best for Deaf people, but you see even if I am Deaf I also like to talk to people.

Remembering a radio station interview that she participated in, Rudo says:

I remember when I was interviewed by the Public Radio Station. I went there with an interpreter, and they said let's talk about Deaf culture. They asked, "Did you go to school? Where do you live? What do you eat?" They asked me a lot of questions and they just gave me 30 minutes to answer all of them, but you see I wanted to talk more. They didn't give me time to say things in the way that I want like you have done. I just had to follow what they wanted.

Rudo sums up her evaluation of the BNIM method by saying:

*I think your interview method is not fake like the others because you are trying to truly understand me. You see, life for a Deaf person is not just about going to school and eating like what the radio station thinks, but it's more than that. As you can see, I have things in my life; my husband's "small house", my divorce, my boyfriend and my babies who died and my church of Pastor **Makandiwa**.*

As postulated by Wengraf (2013), Sub-session 3 enabled me to meet with each participant again, to ask direct questions that are associated with the research agenda, to clarify ambiguous points and to gather more biographical data about each participant. The participants appreciated Sub-session 3 and also took the opportunity to update me about new developments in their experiences of sexuality. For example, Mayita, who has a psychosocial impairment, says:

At first I was thinking that you are like those University people who just come to mental hospital and interview us once and disappear, but I think that your University is different and I see that you are different. I am happy that you have come back because I want to tell you that I am now pregnant and that all my underpants are now torn so I don't have anything to wear for my underneath...

By combining my own methodological reflections and those of participants as illuminated above, I argue that bringing the BNIM method to FDS and AFDS promises further development of the terrain of disability studies. As asserted by Dowse (2009) in as much as it is important for other people to listen and to understand, it is also equally significant for the disabled women themselves to feel pleased and confident that their voice has been heard. Dowse (2009) argues against mainstream medical research which is known for its neglect or failure to consult or empathetically engage disabled people, thereby running the risk of exacerbating the oppression of disabled people. Considering that both mainstream disability and mainstream feminist theorists, particularly in the Global South, appear not to be interested in facilitating the voice of disabled women, the use of BNIM in FDS or BNIM in AFDS presents a novel research tool which permits voices from the periphery to be heard thereby enabling disabled women to share their contextual experiences of sexuality with the world.

The conflation of BNIM and FDS, or BNIM and AFDS, is not only likely to create safe spaces for voices from the periphery to be heard, but the approach also promises to solicit the views of disabled women about the method itself and the researcher. That is not to say that other creative methods are not useful in seeking to understand the multidimensional and multi-layered experiences of sexuality of disabled women. But, it is to say that the BNIM method under an overarching narrative research paradigm supports a kind of research which, in resonance with an assertion made by Dowse (2009), seeks to go beyond the practice of classifying and pathologising; an approach which is common in mainstream medical research and which seeks to cure, modify and normalise people who are situated as docile and “abnormal” human beings. BNIM can address the intricacies of cultural, economic and social relations that create the life worlds of disabled women who have historically been labelled as disabled and asexual beings.

Conclusion

By conflating FDS as an overarching conceptual framework for this study and the narrative methodology, I was able to recognise the diverse ways through which disabled women in Zimbabwe construct their own understanding of what it means to be disabled and sexual. The FDS perspectives that I drew in relation to power, the body and sexuality, the social model of disability and intersectionality have been able to support the narrative methodology. In

particular, the ambiguity and open-endedness of intersectionality (Davis, 2008) enabled me to consider the various ways in which a narrative approach could uncover the concealed complexities that surround the disabled women's experiences of sexuality, whilst at the same time attempting to evade a generalising or essentializing approach. As postulated by Cole (2009), the vagueness of intersectionality works well with a study of individual experiences where the chance to ask new questions abound and where a qualitative researcher is not restricted in relation to exploring emerging intersections. The comments that were made by participants regarding the BNIM method are outstanding; such comments are illustrative of the fact that some disabled women who live both inside and outside of institutions have in the past been on the receiving end of researcher expertise. In addition, the comments of participants illuminate the fact that disabled women who are evidently located at the peripheries of society are appreciative of a platform upon which their voices can be heard as they openly share their experiences of disability and sexuality with the world. In the next chapter, I outline the recommendations and conclusion of this study.

CHAPTER NINE

RECOMMENDATIONS AND CONCLUSION

The findings of this study reveal that similar to all other human beings, sexuality forms a core part of the lives of disabled women and neglecting the subject would be detrimental to the health and well-being of the women. I therefore discuss the recommendations that arise from the findings of this study in relation to policy, services, DPOs, civil society and disabled women themselves, below.

9.1 Policy

The Government of Zimbabwe should take urgent steps to overhaul the Disabled Persons Act (DPA),(1992), in an effort to align the main disability law of the country with the provisions of the United Nations Convention on the rights of Persons with Disabilities, CRPD (United Nations, 2008). Such an alignment holds the promise of addressing the concerns of disabled women that have emerged in the findings of this study and specifically as outlined below:

Table 5: Alignment of the DPA (1992) with the CRPD (2008)

CRPD Provision	Benefits of aligning the DPA and the CRPD
Article 6; Women with disabilities	State to ensure that disabled girls and women have full and equal enjoyment of all human rights and fundamental freedoms.
Article 8; Awareness raising	To contest myths, prejudices and harmful practices that arise from discursive constructions of truth regarding issues of disability and sexuality.
Article 13; Access to justice	Disabled women to have appropriate access to the justice delivery system. Officials to be trained in disability issues.
Article 16; Freedom from exploitation, violence and abuse	To make provision for the protection of disabled girls and women against all forms of GBV; to ensure the availability of GBV

	recovery programmes.
Article 22; Respect to privacy	Disabled women to gain legal protection from unreasonable interference with their privacy, particularly those who live in institutions.
Article 24; Education	Inclusion of disabled girls and women in education. Approximately a third of participants in this study reported that they never went to school.
Article 25; Affordable healthcare	Affordable healthcare including sexual and reproductive healthcare to be brought close to communities including in rural areas.
Article 27; Work and employment	The current DPA prohibits discrimination of disabled people in the workplace but it does not award disabled people the right to work. More than half of participants in this study reported that they are not formally employed.
Article 28; Adequate standard of living and social protection	Social protection and poverty reduction programmes for disabled women and girls. Almost all participants who took part in this study reported poverty and abuse.

The Government of Zimbabwe should ensure that the subjects of gender and sexuality are visible in local disability legislation. That is so because the existing DPA is gender blind and yet gender neutral laws are not equally applicable to all disabled people. In addition, if the subject of sexuality fails to appear in disability legislation, the identity marker of disability will continue to be foregrounded at the express exclusion of other significant identity markers, such as gender and sexuality, which intersect with disability to frame the life worlds of all disabled people including those of girls and women.

- The Government of Zimbabwe also needs to urgently re-align the out-dated DPA with the new Constitution (Government of Zimbabwe, 2013), which contains progressive provisions albeit the fact that it references people with physical and mental disabilities at the express exclusion of people with sensory and intellectual impairments; and to further support the legislation with adequate funding, staffing and awareness campaigns among other initiatives. Given the conflict that appears to reign between international legal instruments and traditional practices, there is need for policy makers and implementers to make an effort to reconcile the law with cultural practices; if at all the concerns of disabled African women in Zimbabwe are to be effectively addressed. In addition, there is need for disabled women to be appraised

on the provisions of the relevant laws, so that they may be able to exercise the rights that are guaranteed to them by the laws.

- The Ministry of Health and Childcare should establish a policy which directs all players in the three mode healthcare system in Zimbabwe to collaborate in the provision of healthcare, particularly in aspects that are related to “curing” impairment. Such an approach is likely to reduce suspicion and antagonism among religious, traditional and contemporary healthcare practitioners, which prevails at the detriment of the health and well-being of disabled women who simultaneously consult all the three modes of healthcare.
- The recruitment policy of the health sector should consider the inclusion of disabled women themselves at various levels. Such a policy has the potential to create an opportunity for trained disabled women to bring positive change to the sector, thereby enhancing sectoral sensitivity to the needs of sexuality of disabled women. Furthermore, I recommend the inclusion of the subject of disability and sexuality in the curriculum of all healthcare professionals. Such training is likely to bring consciousness to the unique needs of disabled women within the healthcare delivery system.
- There is need for the Ministry of Health and Child Care in Zimbabwe to establish a policy which directs all healthcare institutions to ensure the availability of healthcare facilities that enable disabled women to be appropriately and adequately attended to and to offer communication in appropriate formats such as Braille for the visually impaired and sign language for the Deaf. Training should include a rigorous evaluation of impact which enables the voice of disabled women to feed back into the policy-making systems to allow for necessary and relevant changes to be made.
- The Ministry of Education, Sport, Arts and Culture and the Ministry of Higher and Tertiary Education should introduce an education policy which enforces and monitors the mainstreaming of a holistic sexuality education programme in all schools, including special schools. Sex education raises the sexual awareness of disabled girls,

thereby providing them with information and skills that are required to foster responsible and healthy sexual practices, even in their adulthood.

9.2 Services

The high prevalence of GBV among disabled women as reported by participants calls for:

- The development sector in partnership with the government of Zimbabwe to consider establishing disability friendly shelters for disabled women in both rural and urban areas across the nation. Such shelters could also offer advice on the identification of abusive practices and how the women could respond. The recruitment of disabled women to work in such shelters, including some disabled women who may have survived GBV themselves, is recommended on the grounds that such women are unlikely to defend or demean the abuse that is reported by fellow disabled women, as is common in the mainstream justice delivery system. However, such centres should not work in isolation but they should collaborate with other professionals in traditional settings such as police stations, rehabilitation centres and hospitals; hence it is important to mainstream disability across all sectors.
- HIV/AIDS intervention programmes should consciously include disabled persons in their programming. The findings of this study indicate that current practice and dialogue offers blanket solutions to communities at the exclusion of disabled people and their specific needs and yet HIV prevention calls for a multidimensional approach if it is to reach all vulnerable groups including disabled women. However, there is need to include men in HIV prevention programmes, given that, as noted by Kalichman et al. (1998), assigning the responsibility of negotiating safe sex squarely to women may turn out to be burdensome, given that compared to other women, disabled women may encounter several barriers to the accomplishment of safe sexual practices.

9.3 DPOs and civil society

The findings of this study indicate the invisibility of DPOs and civil society support for disabled women. I therefore recommend that:

- Civil society and DPOs should make efforts to acknowledge the significance of the CRPD in the recognition of the rights of persons with disabilities in order to meaningfully lobby and advocate for the full inclusion of disabled persons in all areas of life. However, as discussed in Section 9.1, the “voyage” ought to begin with the alignment of the local DPA with the CRPD. The CRPD, coupled with a revised DPA, form an important foundation for civil society and DPO work in disability and sexuality issues. The application of such legal instruments could go a long way in contributing towards the promotion of the rights of disabled people, as well as to protect and raise awareness of the sexual rights of people with disabilities, including girls and women.
- Civil society and DPOs need to encourage the open acknowledgement and discussion of the subject of sexuality of disabled girls and women in families, schools, churches, rehabilitation institutions and healthcare centres; from a constructive religious, traditional and contemporary perspective. Open discussions will enable an appropriate understanding of the sexuality of disabled girls and women, thereby safeguarding the health and general well-being of disabled girls and women, given the fact that no human being is asexual.
- Civil society and DPOs ought to work together and across all sectors to raise awareness of GBV that is perpetrated against disabled women, thereby reducing ignorance or indifference to the subject. As highlighted by Elman (2011), indifference may be interpreted to mean tolerance or permissiveness, thereby sending a potent and incorrect message to perpetrators. Civil society and DPOs should develop their own strategies for pursuing prosecution, thereby making it easier for authorities to intervene in GBV that is perpetrated against disabled women.

9.4 Disabled women

The findings of this study indicate that although disabled women may share common experiences of sexuality, the women are isolated from one another. Such a situation makes it difficult for disabled women to mount a struggle which collectively challenges the diverse range of oppressive practices that disabled women may be subjected to (Thomas, 2006). I therefore recommend that:

- Disabled women in Zimbabwe should borrow the concept of self advocacy from Britain, which, as articulated by Dowse (2001), represents an approach that is taken by disabled people to enable them to speak out so that their voices can be heard as they seek to contest the landscape of their life worlds. By taking such an approach, albeit in a collective way, disabled women may be able to challenge practices of oppression that characterise their experiences of sexuality as revealed by the findings of this study. However, there is need for civil society and DPOs to collaborate and to assist disabled women to organise by providing the women with both a focal point and a place of convergence.
- Disabled women in Zimbabwe should adopt the concept of peer counselling. Such a self-help programme holds the potential to enable the self-growth of disabled women, given that a disabled woman who belongs to a peer group is likely to realise that she is not the only one with particular feelings or perceptions about her unique body and circumstances (Saxton, 1981). By sharing their own experiences of sexuality, disabled women may be able to assist one another in a myriad of ways. As is common with other studies, this study has its own limitations, which I outline below.

9.5 Limitations of research

This study has its own limitations. As noted in Chapter 1, there are two major vernacular languages in Zimbabwe which are encompassed in the indigenous population, namely Shona and Ndebele. Shona, from which the sample was drawn, forms the larger part of the citizenry at approximately 85%, and Ndebele forms approximately 15% of the indigenous population. Although the sample for this study was drawn from the Shona people, who form the larger

part of the indigenous population, it is not possible to generalise the findings of this study to the women of the Ndebele tribe who may or may not have different ethnic conceptualisations of disability and sexuality.

Conclusion

This study arose from the uneasiness I felt when a woman who is disabled with dwarfism mentioned that she had been disappointed by her male intimate partner. The research explored the experiences of sexuality of disabled women in Zimbabwe. Considering that the topic is rarely researched and that this study is the first of its kind in Zimbabwe, the research has made an original contribution to the body of knowledge by enhancing the comprehension of the experiences of sexuality of disabled women and suggesting the development of indigenous theoretical formulations that are rooted in the African context. In addition, the use of the unique and novel research method of BNIM within the narrative methodology reveals the originality of the method. By facilitating the voice of disabled women in Zimbabwe, this study has created space in which disabled women could directly contribute towards bringing their experiences of sexuality from the periphery of society to the fore. It is evident that through their own voice, disabled women in Zimbabwe have disrupted the myth that disabled women are asexual beings; I can only hope that there will be ears that will be willing to listen.

Figure 7: Inside a participant's home – the kitchen



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APPENDICES

Appendix 1: Ethical Approval – University of Cape Town



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6338 • Facsimile [021] 406 6411
Email: linsey.samuels@uct.ac.za
Website: www.health.uct.ac.za/research/humanethics/forms

26 September 2013

HREC REF: 581/2013

Dr J McKenzie
Health and Rehab Sciences
F45
OMB

Dear Dr McKenzie

PROJECT TITLE: A NARRATIVE STUDY OF THE LIVED EXPERIENCES OF SEXUALITY OF DISABLED WOMEN IN ZIMBABWE

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th September 2014

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period. (Forms can be found on our website: www.health.uct.ac.za/research/humanethics/forms)

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC reference in all your correspondence.

Yours sincerely

PP TuBurgess

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation



UNIVERSITY OF CAPE TOWN
UNIVERSITEIT VAN KAAPSTAD

HUMAN RESEARCH
ETHICS COMMITTEE

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee



19 SEP 2014
FHS016: Annual Progress Report / Renewal
HEALTH SCIENCES FACULTY

HREC office use only (FWA00001637, IRB00001938) CAPE TOWN			
This serves as notification of annual approval, including any documentation described below.			
<input checked="" type="checkbox"/> Approved	Annual progress report	Approved until/next renewal date	30.09.2015
<input type="checkbox"/> Not approved	See attached comments		
Signature Chairperson of the HREC		pp T. Burgess	Date Signed 19/09/2014

Comments to PI from the HREC:

Principal Investigator to complete the following:

1. Protocol information

Date (when submitting this form)	18 SEPTEMBER 2014		
HREC REF Number	581/2013	Current Ethics Approval was granted until	30/09/2014
Protocol title	A narrative study of the lived experiences of sexuality of disabled women in Zimbabwe.		
Protocol number (if applicable)			
Are there any sub-studies linked to this study?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If yes, could you please provide the HREC Ref's for all sub-studies? Note: A separate FHS016 must be submitted for each sub-study.			
Principal Investigator	CHRISTINE PETA Supervisor: Dr Judith McKenzie		
Department / Office Internal Mail Address	DISABILITY STUDIES DIVISION, DEPARTMENT OF HEALTH AND REHABILITATION SCIENCES, FACULTY OF HEALTH SCIENCES F45 OLD MAIN BUILDING, GROOTE SCHUUR HOSPITAL OBSERVATORY 7925		

1.1 Does this protocol receive US Federal funding?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
1.2 If the study receives US Federal Funding, does the annual report require full committee approval?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1.3 Has sponsorship of this study changed? If yes, please attach a revised summary of the budget.	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No



UNIVERSITY OF CAPE TOWN
UNIVERSITEIT VAN KAAPSTAD

HUMAN RESEARCH ETHICS COMMITTEE

17 SEP 2015

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee



FHS016: Annual Progress Report / Renewal

HREC office use only (EWA00001837; IRB00001938)

This serves as notification of annual approval, including any documentation described below.

<input checked="" type="checkbox"/> Approved	Annual progress report	Approved until/next renewal date	20.9.2016
<input type="checkbox"/> Not approved	See attached comments		
Signature Chairperson of the HREC		Date Signed	17/9/15

Comments to PI from the HREC

Principal Investigator to complete the following:

1. Protocol information

Date (when submitting this form)	9 SEPTEMBER 2015		
HREC REF Number	581/2013	Current Ethics Approval was granted until	30/09/2015
Protocol title	Voices from the periphery: A narrative study of the lived experiences of sexuality of disabled women in Zimbabwe.		
Protocol number (if applicable)			
Are there any sub-studies linked to this study?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
If yes, could you please provide the HREC Ref's for all sub-studies? Note: A separate FHS016 must be submitted for each sub-study.			
Principal Investigator	Dr. Judith McKenzle		
Department / Office	Disability Studies Division, Department of Health and Rehabilitation Sciences, Faculty of Health Sciences		
Internal Mail Address	F45 Old Main Building, Groote Schuur Hospital Observatory 7925		

1.1 Does this protocol receive US Federal funding?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
1.2 If the study receives US Federal Funding, does the annual report require full committee approval?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
1.3 Has sponsorship of this study changed? If yes, please attach a revised summary of the budget.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

23 July 2014

Page 1 of 5

FHS016

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

Appendix 2: Ethical approval – Medical Research Council of Zimbabwe

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: <http://www.mrcz.org.zw>



Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CV 573
Causeway
Harare

APPROVAL

Ref: MRCZ/A/1789

13 February, 2014

Christine Peta
University of Cape Town
Faculty of Health Sciences
South Africa

RE:- A Narrative Study of the Lived Experiences of Sexuality of Disabled Women in Zimbabwe

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has reviewed and approved your application to conduct the above titled study. This is based on the following documents that were submitted to the MRCZ for review:

- a) Research Proposal
- b) Informed Consent Form (English and Shona)
- c) Questionnaire (English and Shona)

• **APPROVAL NUMBER** : MRCZ/B/1789

This number should be used on all correspondence, consent forms and documents as appropriate.

• **TYPE OF REVIEW** : Full Board

• **EFFECTIVE APPROVAL DATE** : 13 February 2014

• **EXPIRATION DATE** : 12 February 2015

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Website should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Website.
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Website is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Website.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully


MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE



PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

Telephone: 791792/791193
Telefax: (263) - 4 - 798715
E-mail: mrcz@mrcz.org.zw
Website: <http://www.mrcz.org.zw>



Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

CONTINUING REVIEW APPROVAL

Ref: MRCZ/A/1789

12 February, 2015

Christine Peta
University of Cape Town
Faculty of Health Sciences
South Africa

RE:- A Narrative Study of the Lived Experiences of Sexuality of Disabled Women in Zimbabwe

Thank you for the application for approval to continue carrying out research activity that you submitted for review to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to continue conducting the above titled study

This approval is based on:-

- a) MRCZ Form 102
- b) Progress Report
- c)

• **APPROVAL NUMBER** : MRCZ/B/1789

This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF REVIEW** : Full Board
- **EFFECTIVE APPROVAL DATE** : 12 February 2015
- **EXPIRATION DATE** : 11 February 2016

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Website should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Website.
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Website is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Website.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

**MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE**



PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

Appendix 3: Letter of information in English

Title of study: Voices from the periphery: A narrative study of the experiences of sexuality of disabled women in Zimbabwe

17 July, 2013

Dear Participant,

My name is Christine Peta and I am a PhD student at the University of Cape Town. I am conducting a study on the experiences of sexuality of disabled women in Zimbabwe, to fulfil the requirements of my studies towards a PhD in Disability Studies. This information sheet is designed to help you to decide if you want to take part in this study or not. Before you decide, you can discuss contents of this letter with any of your family members or friends or any other person of your choice.

(1) Who is carrying out the study?

I am conducting the study under the supervision of Dr Judith McKenzie, in the Disability Studies Programme – School of Health and Rehabilitation Sciences.

(2) Who is taking part in this study?

Participation in this study is meant for disabled women of age group 18-65 who are residing in Harare.

(3) What is the study about?

This study seeks to explore the experiences of sexuality of disabled women in Zimbabwe. Very little has been researched or is known about the sexual experiences of Zimbabwean disabled women. Talking about your experiences is therefore important so that your experiences can be illuminated and recommendations for effective disability practice in the country can be made.

(4) What are you expected to do in participating in this study?

For the research, you are invited to have 3 interview sessions with the researcher. The first two sessions will take place in one day, and the third session will take place on a separate day. The interviews will be recorded for the researcher to analyse.

You will make a joint decision with the researcher, on the most suitable, accessible and private area where the interviews will be conducted. Discussion will include your experiences of living with disability in Zimbabwe in relation to your love and sexual relationships, including issues of pregnancy and childbirth, if any.

(5) How much time will the study take?

The first session of the interview is expected to take approximately 45 minutes, the second session 75 minutes and the third 90 minutes.

(6) Where and how will the information be kept?

All your identity information such as name, telephone number, email, address and any other identifying features is confidential and will not be accessible to anyone, other than the researcher, the co-researchers and the supervisor. Papers about the study may be published in a journal, but identity information of participants will remain confidential. Pseudonyms will be used to conceal your true name both during the study, in the final report and in any journal publication.

Where the researcher is given information which points to different sexual orientations other than heterosexuality, the researcher will not reveal the true identity of the participant, but she will conceal the true name of the participant during the study, in the final report and in any publications that may arise from this study.

(7) Will the study benefit me?

There is no monetary payment for participating in this study. It is expected that participants will benefit from self-knowledge when the results are given. By openly sharing your experiences of sexuality, participants may become a voice for others in more or less similar situations who have not participated in the research.

(8) Are there any dangers involved in taking part in this study?

It is expected that the interview may open some wounds of previous traumatising experiences and some participants may become anxious or tense. In the event that this happens, the researcher will offer the participant a free referral service for psychosocial support and counselling as well as free legal services.

(9) Can I tell other people about the study?

You are free to discuss this study with your relatives or friends or other people of your choice.

(10) Should I take part in this study?

It is up to you to decide whether you should take part in this study or not. Completing and signing the consent form means you are interested in participating. If you are not interested in participating, you do not have to complete or sign the consent form.

(11) Am I allowed to stop participating if I do not like to continue after I have started?

This study allows you to withdraw from it anytime without giving any reasons for your withdrawal from the research. If you decide to withdraw from the study, the audio recording will be deleted and the information given will not be included in the study.

(12) Do you have questions about the study?

If you have any questions about the study, you can contact the researcher on the address, telephone number or email address given below.

(13) What if I have a complaint or any concerns?

If you have any concerns or complaints about this study, you can contact me, my supervisor or the chairperson of the University of Cape Town, Faculty of Health Sciences Research Ethics Committee using contact details given below.

Thank you for taking time to read this letter or to have this letter read to you.

Contact Details of the Researcher

Name	:	Christine Peta
Address	:	152 Portglen Road Ryelands Borrowdale Harare Zimbabwe
Telephone	:	263-774-199-670
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This information sheet is for you to keep

Appendix 4: Informed Consent form in English

Study Title: Voices from the periphery: A narrative study of the experiences of sexuality of disabled women in Zimbabwe

I _____ have read, or _____ has read to me, and I have understood the information about this study. I know that the interviews of this study will be audio-recorded. I have been given a chance to discuss my participation in the research project, with the researcher and all questions that I had about the study have been answered to my satisfaction.

I have not been forced to participate in this research but I have decided to take part of my own free will. I know that I can choose to stop participating in this study at any time, if I am not happy with anything and any information that I could have given that is audio recorded will be erased and will not be used in the study.

It has been explained to me that my participation in this project is strictly on a private and confidential basis. I understand that all of my identity information will be used in a way that only the researcher, co-researchers and supervisor will identify me, and not any other person.

I consent to audio-recording (tick your choice) **YES**_____ **NO**_____

Signed: _____

Participant

Date and place

Signed: _____

Researcher

Date and place

Appendix 5: Letter of information in Braille (Submitted in hard copy format)

Appendix 6: Informed Consent form in Braille (Submitted in hard copy format)

Appendix 7: Letter of information in Shona (vernacular)

Chikamuchenomwe: Mibvunzo nemhinduro yenhaurirano

Musoro: Mazwi anobva kumucheto: Ongororo yemararamiro ezvinosangana nevakadzi vakaremera vemuZimbabwe panyaya dzezvepabonde.

Zita rangu ndinonzi Christine Peta. Ndiri mudzidzi pachikoro chikuru cheCape Town (University of Cape Town). Ndiri mugwaro repamusoro rinodaidzwa kuti PhD munezvevakaremera. Mukuzadzisa zvinodiwa pagwaro iri, ndiri kuongorora nekutsvagurudza mararamiro, uye nezvinosangana nevakadzi vakaremera panyaya dzezvepabonde. Chinyorwa chino chakanyorwa kuti vanoda kupa pfungwa dzavo paongororo yenyaya iyi varatidze kuzvipira kana kusazvipira. Usati wazvipira kuva mumwe wevanhu ava, unogona kuva nenhaurirano pamusoro pezviri pachinyorwa chino nevanhu vehukama, shamwari, kana munhuwo zvake waunoda.

(1) Arikuita ongororo iyi ndiani?

Ndirikuita ongororo iyi ndichibatsirwa nemurairidzi anonzi Dr Judith McKenzie, mubato rezvidzidzo zveutano nekurapwa nekuchengetedzwa kwevakaremera (Disability Studies Programme - Department of Health and Rehabilitation Sciences).

(2) Vanhu vari kuwanikwa paongororo iyi ndivanaani?

Vanhu vari kuita kuti chinyorwa chezvevakaremera chivepo vakadzi vakaremera, vaine makore gumi nemasere kusvika makumi matanhatu nemashanu ekuberekwa vari vagari vemuguta reHarare.

(3) Ongororo iyi ndeyei?

Ongororo iyi iripo kujekesa mararamiro evakadzi vakaremera vari muZimbabwe, takatarisana nenyaya dzezvepabonde, kutakura pamuviri uye kuzvara vana. Kutaura nezvamaramiro ako semudzimai akaremera zvakakosha sezvo zvichipa chidzidzo uye oneso yezvinotarisirwa kuti zviitwe, uye mabatirwo akakodzera anofanirwa kuitwa kuvakaremera munyika ino yeZimbabwe.

(4) Ndezvipi zvaunotarisirwa kuti uite paongororo iyi?

Paongororo iyi, unotarisirwa kuti ugare pasi nemuongorori kana kuti mudzidzi kanokwana katatu, achikubvunza mibvunzo yaunofanira kupindura zviri maererano neongororo yake. Zvikamu zviviri zvekutanga zvinoitwa zuva rimwe chete, chechitatu chozoitwa rimwewo zuva. Mibvunzo nenhaurirano dzose dzichaitwa, zvichatapwa nemuongorori wenyaya kuti zvizomubatsira kana ava kupakura zviwanikwa zvechidzidzo chake.

Zvose zvinhu zvichataurwa, hazviburitswi pachena nemazita kuti ndiani ataura. Muongorori arikukumbira mvumo yenyu kuti zvamuchakurukura zvose zvitapwe. MaCD anenge ashandiswa pakutapa haanyorwe mazita enyu echokwadi, uyezve haateererwe nevamwe vanhu kunze kwemuongorori nemudzidzisi wake chete, uyezve anochengetwa munzvimbo yakakiyiwa. Kana usingade kutapwa, unongokwanisa kuva muchidzidzo zvakare asi mudzidzi achingonyora zvawataura pasina kutapa.

Unotarisirwa zvakare kuti ubvimirane nemuongorori pakusarudza nzvimbo yekuitira nhauriro yenyu, ichiva nzvimbo yakanaka, yakasungunguka, inosvikika zvakanaka, nenguva uye penyu mega. Nhaurirano dzinenge dziripo dzinosanganisira zvawakasangana nazvo paurema hwako uri muZimbabwe, wakatarisana nenyaya dzerudo, zvepabonde uye kuzvitakura pamwe nekuzvara vana.

(5) Ongororo iyi ichatora nguva yakareba sei?

Chikamu chekutanga pakubvunza nekupindura mibvunzo chingangotora maminitisi makumi mana nemashanu, chechipiri chotorawo anosvika makumi manomwe nemashanu uye chekupedzisira chinotarisirwa kuva nemakumi mapfumbamwe. Nhaurirano sechikwata inogona kutora nguva dzepakati peawa rimwe chete kana maviri.

(6) Zvinenge zvawanikwa paongororo iyi zvinochengetwa sei? Uye kupi?

Tsananguro yakaita sezita, nhamba dzenhare, kero yepaunogra kana paunoshanda nezvimwe zvinotsanangudza kuti ndiwe ani hazviudzwi kana kuregedzwa zvichiwoonekwa nevamwe vanhu kunze kwemuongorori numudzidzisi wake chete. Chinyorwa chezvevakaremara ichi chinogona kuiswa pachena kuti veruzhinji vagoverengawo asi tsanangudzo yekuti akapa nhoroondo yezviri muchinyorwa ndiani haiburitswi pachena. Mazita evakadzi vakaremara vanenge vabatsira paongororo haaburitswi pakushambadzwa kwechinyorwa ichi. Iwe nevamwe vakadzi vakaremara vanenge vapinda pachidzidzo muchapiwa zvinenge zvabuda paongororo pasina zita reumwe wenyu richabuda.

Zvakakosha kuti uzive kuti kana ukataura nyaya dzokudanana kwako nevamwe vanhukadzi zita rako hariburitswe pachena asi kuti rinovanzwa munguva yekutora kwako bato muchidzidzo ichi kusanganisira nemunguva yekunge wapedza, zvekare nemune zvimwe zvinyorwa zvingangobuda muchidzidzo ichi.

(7) Chidzidzo ichi chichabatsira ini here?

Hapana mubhadharo wemari uchapiwa kune vachapa tsananguro yezvavakasangana nazvo pakuremara kwavo asi kuti vanotarisirwa kubatsirikana neruzivo kana chinyorwa chapera kunyorwa. Kutaura kwako pachena nezvenyaya dzako dzepabonde kunoreva kuti unogona kuva izwi revamwe vasina kuwana mukana wekutorawo bato muchirongwa ichi.

(8) Pane zvingakuvadza here kana wazvipira kuva muongororo iyi?

Zvinotarisirwawo kuti mibvunzo ichada kupindurwa inogona kuundura maronda ezvairwadza zvakasanganikwa nazvo nevabatsiri veongororo iyi zvoita kuti vave nemarwadzo zvakare. Kana izvi zvaitika, muongorori wenyaya iyi anotarisirwa kuti aendese vakadzi ava kune vanopa mashoko enyaradzo mupfungwa nekudzikamisa maronda epamwoyo.

(9) Ndinogona kuudza vamwe vanhu here nezveongororo iyi?

Wakasununguka kutaura nehama neshamwari kana vamwe vanhu vaunoda nezveongororo iyi?

(10) Ndinogona kuva mumwe wavachabatsira paongororo iyi here?

Zviri kwauri kuzvipira kana kusazvipira kuva pakati pevanhu vari kuda kubatsira pakuti chinyorwa ichi chibude. Kuisa siginecha yako pabepa rino zvinoratidza kuzvipira kwako kuva muchidzidzo ichi. Kana usina kuzvipira regedza kunyora chimwe chinhu pabepa rino.

11) Ndinobvumidzwa kurega kuenderera mberi here kana ndisisade ini ndambotanga?

Unobvumidzwa kurega zvako chero ipi nguva zvayo usingapi zvikonzero zvaita kuti ufunge zvekusiya nekupa pfungwa nenhoroondo yako pachidzidzo ichi. Zvinenge zvakatapwa uchitaura zvole zvinodzimwa uye hazviiswi pakuzononyorwa kwechinyorwa chekupedzisira chichashambadzwa.

12) Une mubvunzo here pamusoro peongororo iyi?

Kana une mibvunzo unogona kuridza nhare dzemuongorori, kumubata pakero yake, kana kero ye-email zvakanonyorwa kwekupedzisira kwebepa rino.

13) Kana ndine kutsutsumwa kana zvandinodawo kuziva pamusoro peongororo iyi ndinoita sei?

Kana une kutsutsumwa kana zvaungadawo kuziva nezveongororo iyi unogona kudiridzira nhare ini semuongorori, mudzidzisi wangu kana mukuru anowongorora nezvekujeka kwezvidzidzo zveutano pachikoro chikuru cheUniversity of Cape Town (Faculty of Health Sciences Research Ethics Committee), muchishandisa kero, nenhamba dzenhare dzapiwa pazasi

Mazvita nekuverenga kana kuzvipa nguva yekuverengerwa chinyorwa chino.

Zita, Kero Nenhamba Dzenhare Dzemuongorori

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**Zita, Kero, Nenhamba Dzenhare Dzemukuru Anoona Nezve Kujeka Kweongororo
Dzezveutano Pachikoro Chikuru cheUniversity of Cape Town**

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*Chinyorwa chino ndechako, saka unogona kugara nacho zvachose kana wapeza kuverenga
zvako.*

Appendix 8: Informed Consent form in Shona (vernacular)

Chikamu Chesere: Bepa rinotaridza kuzvipira kupa nhoroondo pakubvunzwa nekutaurirana

Musoro: Mazwi anobva kumucheto: Ongororo yemararamiro ezvinosangana nevakadzi vakaremera vemuZimbabwe panyaya dzezvepabonde

Ini _____, ndaverenga, kana kuti _____

andiverengera bepa rino. Ndanzwisisa kuti mibvunzo nemhinduro uye nhaurirano dzichaitwa zvichatapwa nemuongorori. Ndapiwa mukana wekutaurirana nemuongorori, ndichibvunza pamusoro pechidzidzo chake ndikapindurwa zvandigutsa.

Handina kumanikidzwa kuri ndipinde muongororo iyi asi kuti ndazvipira ndega. Ndinoziva kuti ndinogona kusarudza kubuda mukuva mumwe wevakadzi vachabatsira kupa nhoroondo chero nguva ipi zvayo kana ndisina kufadzwa nazvo uye kuti zvandakataura zvole zvinodzimwa, zvisingazoshandiswa pakunyorwa kwezvinenge zvakanikwa paongororo iyi.

Zvatsanangurwa kuti kuvapo kwangu kana zvandichataura zvichachengetedzwa zvisingashambadzi kuruzhinji. Nhoroondo yekuti ndini ani haiburitswi pachena asi kuti ichangozivikanwa nemuongorori uye nemudzidzisi wake chete.

Ndinobvuma kutapwa mashoko angu nemuchina.

Hongu _____ Kwete _____

Zita

_____ Zuva nenzvimbo _____

Mubatsiri

Zita

_____ Zuva nenzvimbo _____

Muongorori/Mudzidzi

Appendix 9: Self-designed pro-forma for Single Question Inducing Narrative (SQUIN)

Voices from the periphery: A narrative study of the experiences of sexuality of disabled women in Zimbabwe

The Central Research Question for my project as a whole is:

How do disabled women in Zimbabwe experience their sexuality?

The Central Research Question for my BNIM interviews is:

How do disabled women in Zimbabwe experience their sexuality?

The Theory-Questions into which my Central Research Question unpacks is:

1. How do social life attributes such as age, gender, sexuality, disability, culture, religion and other identity markers intersect to create a disabled woman's oppression?

The type of person whom I am planning this SQUIN for is:

An African disabled woman with either a physical, mental or sensory impairment, aged between 18-65 and living in Harare, Zimbabwe.

The SQUIN

As we have discussed before, I am researching on the experiences of sexuality of disabled women in Zimbabwe.

Could you please tell me about the story of your life, including your experiences as a disabled woman living in Zimbabwe, your intimate love relationships and sexuality involvements, including pregnancy and childbirth experiences that have been important for you up to now.

Begin wherever you like, I will not interrupt.

I will just take some notes in case I have any further questions for after you have finished telling me about it all.

Appendix 10: Example of transcript, Sub-session 1

Mayita (Psychosocial Impairment)

BNIM Interview

Interview date: Saturday 15 February, 2014 (1100hrs to 1530hrs)

Transcript SS1

1.	<p>INT:</p> <p><i>As we have discussed before, I am researching on the experiences of sexuality of disabled women in Zimbabwe. Could you please tell me about the story of your life, including your experiences as a disabled woman living in Zimbabwe, your intimate love relationships and sexuality involvements, including pregnancy and childbirth experiences that have been important for you up to now. Begin wherever you like, I will not interrupt. I will just take some notes in case I have any further questions for after you have finished telling me about it all.</i></p>
2.	<p>I will start from the time when I was a teenager, but No! let me start from the time when I was born, I think that will make my story to come out nicely Christine. I was born on 6 September 1967 in my rural village. I am the second born and eldest girl in a family of 10 children. Our family was very big and very poor. I am now left with one sister and five brothers. Three of my sisters are already dead. When I was growing up I was a shy child, let me emphasise that I was a very shy child. I was very quiet; I would never speak out for myself. I would be bullied up by people and I would just cry. I was the kind of girl who would just get angry inside and not say it. When I was growing up, I went to a local school and in Grade 7 I got the best marks, 4 units. My parents were very happy and I was sent to boarding school. At boarding school I was bullied by others. Because we came from a poor family I could not afford to take to school what others were taking, so I remember the other girls in the dorm would laugh at me. The only thing that was hiding my poverty was that I was very intelligent, so they would laugh at me for not having nice things or shoes or what, but after that they would be coming to me to ask for help with their homework. So they could laugh for a short time, but they would realise that even though I was poor, they still needed my help with their school work, and they would come and I would help them. I hated poverty, so I realised that if I was going to come out of poverty I had to concentrate on school. So whilst others were running around with boyfriends, I wasn't. I didn't have a boyfriend until I was sixteen. I was just behaving very well in school and trying to be careful with what I was doing. I remember that all the girls were menstruating but I wasn't. So I started to think that there was something wrong with me. My menstruation came only when I was in Form 3, about 16 years old, it was delayed because I noticed that other girls were menstruating from the first year we started high school, and all of them were menstruating in Form I at 13 years old. So I was worrying that I was not normal but I was happy when I also started menstruating. At the time I started menstruation, I started to feel that I wanted to love someone of the opposite sex. I was in a boarding school in Kwekwe. I passed my "O" levels with flying colours 4As, 2Bs and 2Cs. I wanted to go to "A" level because I wanted to be an Accountant. My father refused for me to go further with education. My father said it was not necessary to keep sending <i>mwanamusikana</i> (a girl child) to school. My father felt it was better to send boys to school than to send girls, because a girl will just get married and go to a man. You know these African fathers who think that sending a girl child to school is</p>

	<p>a waste of time and money because she will marry and work for her husband's family. My father was that kind of a man. I was hurt, but I had no choice but to stay at home and do nothing because my father had spoken and there was nothing my mother could do. After one year I started to think that it was better for me to kill myself, so I started to think about how to kill myself. I was contemplating suicide every day. I was very hurt and very sad, so I just saw that death was the answer to my problems. I saw that my mother was very worried about me, but there was nothing she could do. It was not possible for her to go against my father's decision. But one day I started to pray and when I was praying, I learnt that my failure to go to school was not the end of the world or the end of life. So I just decided that I will just stay at home with my 8 "O" level passes and see the plan that God had for me. But whilst I was waiting, God gave me an idea. After two weeks of praying, I decided to apply for a place to train as a nurse at <i>Parirenyatwa Hospital</i>. I knew that if I go for nursing training then my father would not have to pay any money for me, the school would pay me an allowance, so my father would not have to do anything. They sent me forms to complete and in like 2 weeks, I got a place and I started to train as a nurse. My father was not worried because he didn't have to pay fees for me. With the money that I was getting as a student nurse allowance, I started to help my mother and my siblings. We were very poor so I could not use the allowance to buy my own things that I wanted but I had to send that money home. By that time, my other brother was now doing a teaching course but he also had to send his student teacher allowance back home because our parents were very poor. I was in 2nd year of my nursing training, when I met my now former husband George. We did a lot of things with George, but now George is history. George is in South Africa with his "small house" and I don't think I miss George. My life just has to go on Christine. I had two other boyfriends. But I didn't do much with these guys because the relationships did not go far. So I can just say that is my story Christine that is all about my life. I have tried to say all the things that have happened to me.</p>
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Appendix 11: Example of transcript, Sub-session 2

BNIM Interview with Mayita (Psychosocial Impairment)

Interview Date: Saturday 15 February, 2014 (1100hrs to 1530hrs)

Notes Prepared Sunday 16 February, 2014 & Monday 17 February, 2014

NO. 6

1.	INT: <i>You said that at the time you started menstruation you started to feel that you wanted to love someone of the opposite sex. Do you remember any particular incident about that time when all that was happening?</i>
2.	I remember that I met <i>Chuma</i> . I started to have a love relationship with him, but he was not very brilliant in school. He was below average. We were not at the same school, he was at a different school in <i>Gweru</i> , but children from both schools knew each other, because our schools would sometimes do sports together and we came from neighbouring villages. So some of the guys in his school used to mock me, and they used to say “ <i>unodanana nedofo, saka ucharichengeta</i> ” (you are in love with a guy who is not bright in school so you are going to be looking after him). Anyway I just kept quiet and I finished my “O” levels and I carried on with nursing. I remember that at that time my relationship with Chuma started to die down, but it was my first love relationship. But with Chuma we were in the relationship for one year and nine months, but we had no touching, kissing or sex, but we were just writing each other love letters. When I went to <i>Parirenyatwa Hospital</i> the relationship died completely. At the hospital I started to feel that I was free from too much poverty that I had been experiencing in the village. We were told that as student nurses we were free to do what we want with our lives; they said they were going to treat us as adults. They said you do what you want as long as you come to work. They came from the School of Nursing and taught us about sexuality. They said every person who is able bodied has a life of sexuality, but they said we should use contraceptives. We were told that we must take contraceptives so that if we have sex we will not get pregnant. They said if you get pregnant you will be chased away from school. They taught us about diseases of sex, like STIs. For me I didn’t care about contraceptives because I had received Jesus Christ as my personal Lord and Saviour. So I continued to keep the church rules and I kept myself whole and pure. I knew that it was wrong to have sex before marriage, so I was not going to do it. I knew that I would give my body to the man who was going to marry me, not just any man. So I can say the Church and the Bible was really helping me to behave myself.
3.	INT: <i>You said you continued to keep the church rules and you kept yourself whole and pure. Do you remember any particular incident about that time when all that was happening?</i>
4.	I remember that I was going to the Family of God Church. I didn’t allow any men to touch my body. I was following the Christian teachings very strictly and I made a decision that I was going to give my body to the man who is going to be patient enough to wait for me to finish school and to marry me after. But I also remember that when I was keeping myself pure, I met a guy who was in the same church with me. He approached me and he said that his name was Roki. I fell in love with Roki. He would take a walk with me at the Botanic Gardens. I was happy that I was now experiencing life away from our...village of poverty. But this guy would sometimes try to kiss me or caress me but I refused any kissing, touching or sex. So I broke up with Roki, because he wanted someone that he could do sex things with.

1.	INT: <i>You said you were in 2nd year of nursing training when you met your now former husband, George. Do you remember any particular incident about that time when all that was happening?</i>
2.	George was a student Pastor Christine. He was a perfect believer. He said people should not kiss, caress or have sex before marriage. He was truly following the rules of the Bible. I think he wanted to be exemplary to members of the church. We went to church together and we were mentored through and through and through. It was in 1986 when I fell in love with George, so 1986, 1987, 1988 and 1989; we were living a Christian life. In 1989 we started to do the customary procedure for marriage. We were not doing any things of sexuality. We were just discussing our future and we were a God fearing couple. I finished my course and qualified as a nurse in 1987.
3.	INT: <i>You said in 1989, you started to do the customary procedure for marriage. Do you remember any particular incident about that time when all that was happening?</i>
4.	In keeping with African tradition, in 1989 we told my <i>tete</i> (father's sister) that we wanted to get married so that she could tell my parents and give us a reply. She came back and said my parents had said they didn't want me to marry George because George was of Indian/European mixture. They said "George is a first class coloured man or a White man, how can we have a son in law like that?" They said he was not going to do for them the things that are expected of a son in law, such as killing a cow or goat in the village and cutting the meat, cutting fire wood or <i>kubata gejo</i> (holding the plough) and ploughing the fields. They also said that <i>varungu</i> (White people) <i>havana hunhu hwechivanhu</i> (are not cultured in the African way). They also thought that I wanted George because he was a White person and I was looking for riches since I had grown up in a poor village; but I knew that mine with George was true and pure love. So my parents said, "if it is money that you want there are a lot of Black business people and even Black Ministers that you can marry, why can't you find a rich Black person, we want a Black man for a <i>mukwasha</i> (son in law), who can do some work for us in the village". They vowed they were not going to allow me to marry George, because of his race. So for me and George our problems began to mount. In my heart I knew I was not after George's money, but I knew that George and I were truly in love and we shared the same Christian beliefs. In fact, George did not have any money because he was just a mere Church Pastor. My parents did not believe that I could fall in love with a White man, and he could also fall in love with me in a very plain and simple way. They thought I had a hidden agenda.
5.	INT: <i>You said so for you and George, your problems began to mount. Do you remember any particular incident about that time when all that was happening?</i>
6.	I remember that on the other side, George's parents said they did not want a Black woman for a <i>muroora</i> , (daughter in law). To quote his mother's exact words, she said: "We don't want a "kafer" in the family, I would rather have my son marry a python and bring it in the home or I would rather he goes to a pub, pick a harlot and bring it home, than for him to marry a Black woman". I was very hurt and George was also very hurt. We spent one year trying to talk to both families so that they could allow us to marry but it was all in vain. All the time I was worrying about my relationship with George. You see Christine; this is the man I had kept myself pure for, saving my body for him. For 4 years we were not touching or kissing and to see that, what we were hoping for was not going to happen was very painful. I was a Student Nurse and he was a Student Pastor and we were both waiting for the day of our marriage so that we could start enjoying things of sexuality as we had promised

	<p>each other. So for me to realise that all our waiting was going to be in vain, it was painful. My parents continued to refuse for us to marry and George's parents also continued to refuse. George said these were the devil's trials, we should continue to love each other and pray. Other fellow pastors and church members were helping us to pray and encouraging us. One day I just broke down and I became mentally disturbed. You see Christine, you can't pray forever; at times you just want things to happen. I just wanted to marry George and I felt I was ready for it. But I can only say that the world was just being cruel on us.</p>
7.	<p>INT: <i>You said one day you just broke down and you became mentally disturbed. Do you remember any particular incident about that time when all that was happening?</i></p>
8.	<p>My parents were shocked because I had always been a quiet girl. But this day I travelled from town to the village, bought them groceries and things and I got home nicely. But all of a sudden I started shouting, "I said to them from today onwards I am going to be rebellious, I will not listen to what you say, I will go and marry George in Court and no one will stop me". I started to break things in the house and shouting at people and taking off my clothes in front of people. This is how my mental disability started. I was taken to hospital and I was admitted into the hospital. I had told George that I would meet with him when I come from the village in 2 days, but this meeting did not take place because I was now in Mental Hospital. So George waited and he didn't see me, so he went to my work and asked and they said they had not seen me. So he was worried and he decided to go looking for me in the village. He just remembered the name of my village area and a school that was near our village because I used to tell him about it. He had never been there. So he went to the <i>Mbare</i> market where I used to board my bus when I was going to the village. The conductors of the rural bus knew him because they used to see him when he was accompanying me to board the bus and they were calling him <i>mukwasha</i>, <i>mukwasha</i> (son in law, son in law). So he went to these guys and asked and they said they could take him to our village if he wanted, because they knew the place. George got on the rural bus and for the first time went to our village in search of me. He said "I will go to the village and find out what happened to Mayita". Using my surname to ask for my people, George got to the school where my father's younger brother was teaching. George knew that my family did not quite like him but he was prepared to face anything because he loved me. He just wanted to find out what had happened to me. At that time I think George loved me a lot. Even up to now Christine I know the colour of love when I see it. I know that a person can find true love in the world.</p>
9.	<p>INT: <i>You said you think at that time you think George loved you a lot. Can you give me a specific example of why you think that way?</i></p>
10.	<p>When he got to the village, they started to tell him very bad things about me, just to put him off. They said "Mayita is now a mad woman; she has gone to the hospital for mad people, so how can you marry a mad woman?" But George just continued to love me. When George got to our village I had been taken to <i>the District Hospital</i>. So my younger sister accompanied George to the hospital but unfortunately by the time they got there I had been transferred that morning to <i>Gweru</i> because I was violent. I was diagnosed with <i>mental disorder</i>, and <i>Gweru</i> had a hospital for mentally challenged people. George followed me to <i>Gweru</i> but when he got there I had been given an injection to calm me down, because I was very violent, breaking things and beating up people. I had truly become a mad woman. So the hospital had isolated me from others and I had been given an injection so that I could just sleep. When George got to the hospital I was drunk with the injection, so he just sat there and waited for me to come round. When I came round, I just woke up and I saw George sitting this</p>

	<p>side and my mother sitting this side. So all I did was jump out of bed and hug George and I started to cry. George said “don’t cry Mayita, because God is able”. He phoned his boss and took leave from his work. George went on leave for 7 months so that he could see me every day. I stayed in <i>Gweru</i> hospital for 2 months and then I was transferred to <i>Ingutsheni Central Hospital for Mental Disabilities in Bulawayo</i>, and I stayed there for five months. I was transferred because <i>Gweru</i> cannot hold mentally disturbed people for a long time, it’s just for emergency but <i>Ingutsheni</i> is a central hospital for psychiatric people only. George was staying close to the hospital, so <i>Ingutsheni</i> was convenient for him because it is also in <i>Bulawayo</i>. So now my situation with George’s parents became worse. Not only was I a Black woman, but now I was a Black woman who is mad. The relationship between me and George’s family became even more tense. But you know Christine, God is able, like what George used to tell me. But God is great because after some time things just started to change. I learnt that God has the power to change things. When I got a mental disorder, I just thought this is it, now George’s parents will never want to see me.</p>
11.	<p>INT: <i>You said, but God is great because after some time things just started to change. Do you remember any particular incident about that time when all that was happening?</i></p>
12.	<p>I remember that George’s sisters were not supporting their parents in their attitude towards me. So they started to condemn their parents, telling them that they were the ones who had caused me to be mentally disturbed because they had refused for me to marry George, the man that I loved. George is the only boy in a family of 4. So in his family, it was him and his 3 sisters. His sisters were not against our relationship so they started accusing their parents of causing my mental disability. So one day, I was shocked to find George’s parents coming to see me at <i>Ingutsheni Hospital</i>. But when they came I was still very mentally unstable, so I wanted to beat them up. They said “Mayita we have come to ask for forgiveness”. But when they said this, I was not moved at all. I was very rude to them. I said “why are you coming to see me, am I now a python that you should come, or am I now a harlot that you should come”. When I said this, George’s parents began to cry, and then when they were crying I wanted to beat them up because I was mentally challenged. The nurses were watching me so they restrained me and put me into seclusion and they gave me an injection. The problem with my disability is that if I am well I can suppress certain feelings and pretend, but if my mental problems come, I can say or do anything. So after the nurses had put me into seclusion, they said to George’s parents, “you can go away because she is still not well”. But George’s parents took the time to explain everything to the nurses about my relationship with George. They explained that I was their son’s girlfriend and that they had refused to accept me as a daughter in law, and they thought that was the reason why I had broken down mentally. The nurses understood the story and they began to counsel me from that day onwards, and in the meantime George just continued to come and see me daily. My relationship with George’s parents began to change. I didn’t think that my relationship with George’s parents was ever going to change, because now I had a mental disorder, but I just started to see it changing. I just thought that maybe it was the power of God.</p>
13.	<p>INT: <i>You said your relationship with George’s parents began to change. Do you remember any particular incident about that time when all that was happening?</i></p>
14.	<p>One weekend they came to <i>Ingutsheni Hospital</i> and asked to take me to their house for the weekend. Although they knew that I was mentally disturbed, I noticed that they were not afraid of me. I just took my medication with me to their house and they</p>

	<p>were reminding me to take it. They bought me clothes and night dresses. I spent a weekend there, I had a nice time. The hospital wrote a letter to my mother and my father and asked them to come to the hospital for family counselling. They also called George's mother and father for counselling. I could see that George's family understood but my own family didn't. My family continued to think that I had been bewitched by people in our village who were jealousy of my success and such witches were causing my madness. They consulted a traditional healer and the traditional healer said people in the village were jealousy because I had finished my course and qualified as a nurse, so they bewitched me. Anyway, my mental disability brought these two families together and they began to talk to each other nicely, believing that God would smile at them and I would one day get out of hospital. So for sure God smiled at our families. That's all I can say Christine, God really smiled on our families.</p>
15.	<p>INT: <i>You said so for sure God smiled at your families. Do you remember any specific incident about that time when all that was happening?</i></p>
16.	<p>I remember that I was discharged from Hospital and I went home and I went back to work, but the problem was that now I was living with a mental disability. I was still in love with my George, but still there was no touching or kissing. We had too much Jesus Christ in us, so George wanted to be exemplary. We were happy, because although I now had a mental disability, George still loved me. We got married in December 1991. George's family paid roora (bride price) for me in my village. In 1991, I went back to <i>Ingutsheni Hospital</i>, this time not as a patient but as a student. I went to specialise, doing a Diploma in Psychiatry. The diploma was for one and a half years. I was at the hospital learning about psychiatry, but I was also mentally challenged myself so I was on medication. I had my own mental problems and even now if I fail to take my medication for one day I go into relapse and I do crazy things. After George's parents had paid the bride price for me, we planned our wedding. In May 1992, we had our wedding. Then that night we went on honey moon at Victoria Falls. This is when I and George started trying to have sex. It was such an experience, a time that I will never forget.</p>
17.	<p>INT: <i>You said this is when you and George started trying to have sex. Do you remember any particular incident about that time when all that was happening?</i></p>
18.	<p>The first night of our honeymoon George tried to break my virginity, but it was a problem. It was very painful and I cried. He tried again the 2nd night but still it was painful I still cried. On the 3rd night George said let's just do it Mayita. I would just push George away when it gets painful and I cried. Nice as he was, George would just go away and leave it for some time and then try again later. He would not force me. Although I was taking my mental medication, I felt that George loved me with his whole heart. We would do other things in between like seeing the Victoria Falls and eating, then we would come back again and George would try to break my virginity. It was not easy. On the 3rd night, George said, Mayita, if we go home without breaking your virginity it is going to be even more difficult when you start screaming and everyone will hear you when we are at home. It's better here, because as you can see we have a sound proof room so when you cry no one hears you. But if we go back home and I try and you cry then everyone will know that now I am breaking your virginity. It will be embarrassing, and we may not be able to come out of the room due to shame. So George kept trying but he only managed to break my virginity on the 3rd night. I remember that when he broke my virginity, I started bleeding. I started feeling that I wanted to pass urine so I rushed to the toilet. Then I saw these things and I called George to say come and see what's there and George</p>

	said those are the things that are called sperms. I also remember that when George broke my virginity we thought about my honeymoon suitcase. Some ladies had told me to pack a suitcase so I had just listened to them and I packed my suitcase. I was young, so I was learning everything from other people.
19.	INT: <i>You said you also remember that when George broke your virginity, you thought about your honeymoon suitcase. Do you remember any particular incident about that time when all that was happening?</i>
20.	I remember that when I was packing my suitcase for the honeymoon there were some elderly women who said you must pack some soft small cloths for the honeymoon. They said, you should take the cloths and use them to wipe your husband's penis. The whole thing didn't make sense to me, but I just packed the cloths anyway and I told George about it. So when George broke my virginity, I was bleeding and he took one of the cloths and wiped my blood. He said he was going to keep that cloth with my blood in a glass, and the cloth would always remind him that he found me a virgin. On that night he also wrote me a letter thanking me for being a woman with good morals and thanking me that I had kept myself well and he had found me a virgin. He said he would always remember that night. When George broke my virginity I was 26 years old. From that day on we had many events of sharing sexuality. When we first arrived at the hotel we kissed and caressed for the first time, both of us felt that we just wanted to have sex, but it was difficult because of my virginity. But I want to tell you the truth Christine, all the days that we were not having sex it's not like we were not human, but it was because we were controlled by the church. We were just holding back but the feelings were there, and there were times when both of us wished time could just fly and we could have sex, but as Christians we had been taught the value of holding back until marriage. We were taught that this is the only way that God was going to bless our marriage. We had decided to follow Church rules, so we had to be strong.
21.	INT: <i>You said from that day on you had many events of sharing sexuality. Do you remember any particular incident about that time when all that was happening?</i>
22.	When we wedded and went on honeymoon I was still at <i>Ingutsheni Hospital</i> , training in my diploma in psychiatry. I was on medication for mental problems but I was also studying. So every weekend I would travel to <i>Harare</i> , because George had gone back to <i>Harare</i> to work. So I would travel every Friday to go to <i>Harare</i> to have sex with George and come back to school on Monday morning. Even George, if he got the slightest chance he would come to <i>Ingutsheni</i> hospital to have sex with me. We became two people who were the greatest lovers of sex. I want to tell you the truth Christine, one thing about me is that I love sex, and it turned out that George also loved sex, so that made the two of us. Our minds were now filled with sex and we were enjoying each other. We could do sex anywhere, bathroom, kitchen, lounge, carpet everywhere. Although I was in <i>Bulawayo</i> and George was in <i>Harare</i> , almost 500kms apart, we made sure that we did not disturb our life of sexuality. When I qualified and finished my Diploma in Psychiatry, I joined George in Harare and we continued to enjoy our sexuality on a full time basis. This time we were always with each other daily and we were now having the full chance. I think our lives were all about sex. We didn't feel guilty because now we knew that we were married, and we were not sinning against God. We felt we had done the right thing.
23.	INT: <i>You said when you qualified and finished your Diploma in Psychiatry, you joined George in Harare and you continued to enjoy your sexuality on a full time basis. Do you remember any particular incident about that time when all that was happening?</i>

24.	<p>Ey! Christine, I remember everything about sex with George. I will never forget. We would go to the bath tub, and we would run some water in the tub. I would just sit and George would wash everything on my body including my vagina, while we are sitting in the bath together. After that we empty the water and put fresh water and I would also wash George's body whilst he is just sitting, I would wash his penis too. George would do everything with me; he would kiss me all over my body, suck my breasts, suck my vagina and I remember that he would put his tongue inside my vagina and I would groan. I was not groaning with pain Christine, but I was groaning with pleasure, it was enjoyment. I would feel his tongue inside my vagina, in the same way that I would feel his penis inside me. George would lick my neck; lick my cheeks and my whole body. He would start licking me from the top downwards to my toes and then he would finish with the vagina. I would also lick his whole body and finally suck his penis. What I found George enjoying the most, was the time when I would suck his nipples, he would just groan with pleasure and he would ejaculate. So I would avoid nipples in the beginning and finish with them later so that he does not ejaculate quickly, because I knew that once I go for his nipples then he would feel so much pleasure and he would ejaculate too early. We got married in May and we did almost everything sexual that after 4 months I got pregnant. It's not like the first 4 months I was barren, but it's because we were using protection so that I could finish my diploma in psychiatric nursing. We knew that if I get pregnant they would chase me from school, so we were trying to time everything so that if I get pregnant like later, the pregnancy would not show before I finish school. So in August we stopped protection knowing that I was graduating in December. We thought that I would leave psychiatric school before they see it, but unfortunately they saw it before I left school. But I think God smiled on me because the school was not fussy with me. By the time I was joining George in Harare, I was already pregnant with our first child. To be honest with you Christine, we loved every moment of it.</p>
25.	<p>INT: <i>You said you think God smiled on you because the school was not fussy with you. Do you remember any particular incident about that time when all that was happening?</i></p>
26.	<p>I think because I was not a stranger. They knew me from the time I was admitted in that hospital with my mental disorders. Before my training I had stayed in <i>Ingutsheni</i> for a long time with my mental problems. I was actually a case study for some students who were studying psychiatry. But now I was also a student. So I think they found my case fascinating because I was once a mental case and now I was a mental student and I had married and wedded but I was also doing all these things and I was also on mental medication. People who didn't know me could not tell that I am living with a mental disability, but those who had taken care of me when I was mentally unstable knew about my mental problems. You see with my type of disability it is not visible, so people just look at me and think that I am a normal woman but I am not. Even here were I am staying I went into relapse and I broke windows. But the people at <i>Ingutsheni Hospital</i> they understood my whole history, so I think they were just trying to be nice to me. They were just saying "you are putting on a lot of weight Mayita; let's hope you are not pregnant". By the time we wrote final exams my pregnancy was showing, but they just decided to ignore it. They bent the rules for me and they did not chase me out of school. So I finished well. Then the time of my pregnancy continued with George when and we were now living together in Harare. George was doing his pastor work in <i>Harare</i>. I can just say that things were just ok!</p>

27.	INT: <i>You said then the time of your pregnancy continued with George and you were now living together in Harare. Do you remember any particular incident about that time when all that was happening?</i>
28.	I remember that I was pregnant with my first child and then I liked sex a lot. I don't want to lie to you Christine I love sex. Even during pregnancy we were having too much sex. My waters broke for delivering the baby, while I was in the middle of having sex with George, early in the morning. If I wake up first, I would say George wake up and let's have sex before you go to work and George would wake up and have sex with me. George was a very nice man. Sometimes I would not wake him up, I would just start to touch his penis or his nipples and he would start to have an erection even in his sleep, and then he just wakes up and we start to have sex. Sometimes I would just say George it's now time for sex and then we would just start to have it. The truth Christine is that both me and George we just loved sex. Now people were saying if you like sex too much during pregnancy it means your child is going to be a girl, and it was true because I gave birth to a baby girl.
29.	INT: <i>You said your waters broke for delivering the baby while you were in the middle of having sex with George early in the morning. Do you remember any particular incident about that time when all that was happening?</i>
30.	Sorry I had forgotten, before my waters broke I had spent like one week in hospital, because my BP was very high. So they put me on bed rest for the BP. But during this time, George would come to see me in hospital everyday and we would have sex at the hospital, we never stopped. I was mentally disturbed so I had the advantage of having my own room, so it was good for me and George because then we never stopped having sex. George would come to see me daily and he would go home after sex. Unfortunately there was a complication with the pregnancy and I had a major operation. Let me take off my clothes so that I can show you the operation. You see here, that is where they cut, you see this big line. This forced us to put our sex life on hold a bit because the wound was still fresh and painful. They said we should have sex after six weeks. But six weeks was too long to wait, so later we just tried to find a position which would not cause too much pain, so that we could just have sex for a few times before the 6 weeks. When I went to hospital I lied that I was not having sex, but I think we had sex maybe four times during the six weeks. George was very happy when I delivered our daughter. To tell you the truth Christine, I was very happily married. I can only say that I thank God for the good marriage I had.
31.	INT: <i>You said you were very happily married. Do you remember any particular incident about that time when all that was happening?</i>
32.	I remember that George's family would visit us; no one was showing a bad attitude. My family also visited. But I think George's family truly changed but my own family I don't think they did. You know Christine, I mean they just continued with their "buts" and "ifs". I believe that my people were forced to change but they didn't change out of their own will. They just didn't want a White man for a son in law and that was that. But I didn't care because I was just focusing on my love with George. They continued to complain that George <i>haasi kutema huni, haasi kubata gejo, haawurayi kana kuvhiya mombe kana mbudzi panhamo</i> (was not cutting down firewood, was not holding the plough and ploughing the fields, was not killing and cutting a cow or goat meat at funerals. I think because George is not Black and he could not do all those traditional things that they expect of <i>mukwasha</i> (son in law) they felt this big vacuum, like they didn't have a real son in law. But for me they had allowed us to marry and that was all that mattered.

33.	INT: <i>You said but you didn't care because you were just focusing on your love with George. Do you remember any particular incident about that time when all that was happening?</i>
34.	I remember that we were truly loving each other, but our problems started in 1993 when I had my second pregnancy. My sexuality with George started to go wrong because when I fell pregnant, George said he didn't want another child. He said "I am a Pastor, where do you think I get money from; I can't look after a large family". At that time we were staying in a block of flats in <i>Glen Norah</i> and my first daughter Chipso was 3 years old. So one day I got home and she said "mummy you work at a hospital, a place where people buy and sell babies, why can't you just buy one baby so that I can have a little sister to play with". So one day I saw her sitting sorrowfully and I asked her what was the problem, she said the other children had refused for her to play with their little sisters and their little brothers and, they were saying she should ask her mother to buy her a little sister or a brother that looks like her. I was hurt, so I flushed my contraceptive tablets into the toilet and I didn't tell George. I only told him one week later that I had stopped. When I told George that I had stopped taking contraceptives there were many problems. You see life is very difficult Christine, I think just going through life is not an easy thing. George was not happy at all and he just began to sulk. I just prayed to God and I said I will wait and see how things go. So I just continued to wait Christine, there was nothing I could do.
35.	INT: <i>You said when you told George that you had stopped taking contraceptives there were many problems. Do you remember any particular incident about that time when all that was happening?</i>
36.	When I told him the reason why I had stopped, he felt I had been foolish, because he said there was no reason for me to make decisions based on what little children were saying. But I felt he didn't see that my daughter was the only coloured girl in the complex and I felt that they were isolating her because of the colour of her skin and I felt she needed a coloured sibling to play with. Anyway he asked me to get back on contraceptives but I decided to get myself checked first. When I checked, it was too late because I had already fallen pregnant, in the course of that week. George was not happy at all, he started to treat me badly. He said he wanted one child only. I never understood why George just wanted one child only and I thought maybe he was also going mad and he needed mental tablets. Unlike my first pregnancy, this pregnancy was making me sick, but then George just didn't care. If I say I am sick, he would say "you brought trouble upon yourself; this is of your own making". But when the baby was born he was happy, but I don't think he ever forgave me. I just think that deep in his heart he was angry with me for deciding to have a 2 nd child and stopping the contraceptives.
37.	INT: <i>You said when the baby was born he was happy but you don't think he ever forgave you. Can you give me a specific example of why you think that way?</i>
38.	If George comes in the bedroom and I am sleeping, he would not greet me; he would just undress and hang his suit and go out of the room. George started to have " <i>small houses</i> " (mistresses), you know these mistresses that other people are now calling <i>smell houses</i> because of the problems they are causing in marriages. George began to hate me as if he was not my husband. But for the children Christine, he showed them love. So I started to just ignore George also and I started to concentrate on taking care of my house maid and daughter. He had changed bedroom when I was 5 months pregnant and he only came back to our bedroom 7 months after our second daughter was born and that was like one year later. That girl that I showed you in the

	picture when you came in, is my 2nd daughter and the man you saw in the picture is George. So now this daughter whose pregnancy he didn't like looks so much like him, and she is very close to her dad. She is now 17. But for me I was struggling I didn't understand why George was reacting that way.
39.	INT: <i>You said George began to hate you as if he was not your husband. Do you remember any particular incident about that time when all that was happening?</i>
40.	I remember that George was no more a Church Pastor in his behaviour. He would come home with lipstick or women's perfume smelling on his body. George left me and he ran away with a <i>small house</i> . She is also a Black African woman and now they have two children. George is now working in South Africa, he did marketing at Trust Academy when he was still in Zimbabwe and I was paying fees for him. So imagine now he runs away with another woman after I have paid fees for his education. When George left I went into relapse. But then I saw George again in 2005. But when I look back now, I just see that it's the work of the devil. George was a committed Church Pastor. Imagine we went into our relationship from 1986 to 1991 and stayed all those years without doing any sex until our wedding day in 1991. George was a true man of God until the devil attacked him.
41.	INT: <i>You said but then you saw George again in 2005. Do you remember any particular incident about that time when all that was happening?</i>
42.	George left for South Africa in 2000 and he came back in 2005. He went again and he came back in 2009. In 2009, I decided to change things between me and George. I saw that when he came back he was now very fat and he was driving a nice car. He apologised to me and asked for forgiveness, but I was still very bitter. I was bruised inside. I found it hard to forgive. About the things of God, George at that time was now going backwards, drinking and womanising. George would go with his friends for 3 days and he would come back with lipstick and smelling of other women's perfume. I confronted him and he came to the open. He said that he was seeing other women. But when George came back to Zimbabwe in 2005 and tried to negotiate with me, I said No! Because I knew he was living with another woman in South Africa and I was not healed from the pain that he had caused me.
43.	INT: <i>You said in 2009, you decided to change things between you and George. Do you remember any particular incident about that time when all that was happening?</i>
44.	Christine, I remember that I sent the children to George. I started thinking that when he went away my first daughter Chipu was in Grade 2 and about six years old and by the time George came back, Chipu was about 15 years old, and when George went, Noku was a little girl who was about 2 years old, but by that time when George came back Noku was about 12 years old. So I thought George was not being fair on me, leaving me to fend for the children on my own, when he knew very well that I have a mental disability. Although my disability is not visible, it's still a disability which gives me problems here and there. You know in 2009, that's when life became very difficult in Zimbabwe and small children and even adults were dying of hunger. So when George got to their house, a neighbour, who happened to be his mother's sister, and she lived at a house which was opposite the house of George's parents, phoned me to say George is here but he is with a "small house". I was very cross; my children were suffering, going without food sometimes because I was earning a very small Zimbabwe Dollar salary. And imagine because of my mental disability sometimes when life gets very harsh I go into relapse and I can't work. So I simply bundled my children and I sent them to George. He said "Mayita lets reconcile" and I said "George is it because you now have the burden of looking after the children". At that time I was working at a rural hospital, as a psychiatric nurse, but you see my relapses

	would come and go, I was not very well myself although I was also trying to help people who were also mentally disturbed. It was hard but I just had to carry on. After that I retired on medical grounds. But now I live here, but sometimes when I get a mental relapse, I can break all these windows. In 2009 I broke all the windows of this house that you see, when I went into relapse.
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NO. 8

1.	INT: <i>You said George is in South Africa with his “small house” and you don’t think you miss George. Can you give me a specific example of why you think that way?</i>
2.	I think I don’t miss him because I have Jabu. When George left I said “I can’t feed my vagina with porridge so I need to find a penis to feed my vagina”. So I am now feeding my vagina with Jabu’s penis, but I am still training Jabu, because he is not very good with sex, but he is not very bad, he is just trying but he is not good like George. But you see I said it’s better to have a penis than to have none at all. When I start to think of sex with George, I used to put my fingers inside my vagina so that I can just feel the thrust, so I just thought a real penis is better than my fingers. I love sex, but Jabu doesn’t have any experience of sexuality, but I have experience, so for now I am his teacher. I just teach him as we go along. To be honest with you Christine I just miss the good sexuality that I shared with George, because Jabu doesn’t want to suck my breasts. When I ask him to suck my breasts, he says “I am not a child so why should I drink milk”. I don’t miss George’s penis, because Jabu has a bigger penis, it’s very big Christine, much bigger than George’s. It’s so big that when Jabu had sex with me the first time, I felt pain, and you know even this favourite position of mine where I have to kneel down and he penetrates me from the behind, it was still painful, but now I am trying to get used to his big penis. Jabu has his own assets that are very good for sexuality. You are the only person that I am telling about Jabu’s private assets, I don’t tell other women because I think that if they get to know, they may try to steal Jabu from me, and they can enjoy him. I am the one who is giving Jabu sexuality training so I think it’s only fair if I am the one who enjoys him when he becomes good. But, the only problem is that Jabu doesn’t lick my vagina but he wants me to suck his penis. So what I do for Jabu is that I wash his penis first, wipe it, then I suck it. I just make sure it’s clean before I suck it. When I do that, he groans with pleasure and after that I expect him to lick my breasts or my vagina but he doesn’t. He just begins to fall asleep. This is the thing that George taught me and I liked it, but Jabu doesn’t do it. But anyway, I am going to get married to Jabu so I just have to keep training him; I believe that he will get into tune and suck my breasts and vagina one day. I think I just have to forget about George, because with George I think my family never really accepted him anyway. I say that because I compare with Jabu. When I took Jabu to them for introduction they were very happy, they said “ndiye anonzi mukwasha kauyu, anotema huni, nekubata gejo, anoenda kuchigayo” (this is what is called a son in law, a man who cuts down firewood, holds the plough and ploughs the fields and he goes to the grinding mill) and true Jabu did all those things for them, he carried bags of maize to the grinding meal and brought the mealie meal for them whilst they were just sitting. Jabu also went to the fields to plough and he cut down lots of firewood for them. I was introduced to Jabu’s family in <i>Centenary</i> in August 2012 and then I also introduced him to my family later. When we went to my family Jabu did all that traditional village work for them and they were very impressed. Although Jabu has a mental disability and George is able bodied, I could see that my family preferred a Black

	<p><i>mukwasha</i> (son in law) who is schizophrenic, than a White <i>mukwasha</i>, who is mentally stable. I think Jabu has his own problems. I noted that they just wanted Jabu because he was doing the customary son in law work and not George because George could not do all that traditional work for them. When we were at the village, I thought about George and I looked at Jabu and I thought ay! my family is a very funny kind of people; they prefer a mentally disabled son in law compared to one who is mentally stable.</p>
3.	<p>INT: <i>You said you think Jabu has his own problems. Can you give me a specific example of why you think that way?</i></p>
4.	<p>Jabu has a mental disability; he is Schizophrenic. But I was told that at the beginning Jabu was an intelligent, well behaved boy who listened to his parents, but he was bewitched when he was writing his “O” level exams. He just wrote one paper and then he started to go mad, so he never really got to finish his exams. But the paper he wrote he got a “B”, so I think if he had not gone mad at the time, he would have done well. But at the time that Jabu got mentally disturbed he was 18 years old. Just like my family, his family is also very poor. I heard that Jabu’s father was drinking a lot of alcohol and he was neglecting his wife and as the first born child, Jabu was hurt. The mother was not working but the father was working as a mechanic and squandering all his money with prostitutes and leaving Jabu, his mother and his siblings in poverty. So Jabu is the first born in his family of 8 children, but the other three are dead. So he grew up seeing all those things of ill-treatment from his father and he got hurt by the treatment that his father was giving to his mother. Jabu attempted suicide by taking a tobacco pesticide but unfortunately he did not die. I think it’s the pesticide that caused his mental disability but I am not sure. Jabu has never gone to town; he just went mad and stayed in the village with his mental disability until the time that he was about 45 years old in 2011, when he got on the bus for the first time, to go to <i>rehab</i> where he met me. He was sent to the centre by a nurse from their rural local clinic. So I am kind of his first love. I am teaching him all these things about sex because he doesn’t know. Jabu is on medication for schizophrenia. I fell in love with Jabu and I am his first love but not his first sex partner. I think we just do disorderly things with Jabu. It’s not really proper things Christine, but Jabu is trying. I am just getting married to Janu anyway, so we will make arrangements for the traditional marriage very soon.</p>
5.	<p>INT: <i>You said you think you just do disorderly things with Jabu. Can you give me a specific example of why you think that way?</i></p>
6.	<p>You see Christine, Jabu told me that before meeting with me, he just had one sexual experience with a woman, and that is for all his life until he met me. So just imagine that he had one sexual experience when he was 26 and he stopped, then he started to have sex with me when he was 46 years old. So Jabu did not have any sexuality experience for like 20 years. He said when he was at his rural home in <i>Centenary</i>; his brother took him to a growth point. His brother decided to pay a prostitute so that Jabu could have sex with the prostitute. The brother knew that Jabu had never had sex in his life and by that time Jabu was 26 years old. So the brother paid, but John is the one who had sex with the prostitute, but on his brother’s money. The brother was just waiting outside when Jabu was having sex with the prostitute. Now I am having sex with Jabu but my problem is that Jabu doesn’t know how to do it well, so I can’t help it but I just start to think of my sex with George. With Jabu I have to keep talking and saying “Jabu now touch here, now suck here, now suck my breasts”, and he just does a little bit and he stops. But with George I didn’t tell him where to touch or kiss or suck but he just knew how to do it. With Jabu I am actually training him</p>

	<p>about sexuality, but I think it's ok! because now he is coming up. Jabu takes time to ejaculate, but once he ejaculates that's it. He will not have sex with me more than once a day. After ejaculation he doesn't want to be touched. But you see with George I knew that if I hear this sound, it means George is about to ejaculate and I would know what to do; George would also know what to do with me. We had studied each other's bodies. I could have 3 or 4 orgasms before he ejaculates, but with Jabu he ejaculates even before my orgasm and he is not bothered. But with George we would make sure that we are both satisfied. But with Jabu if he ejaculates once, I can't ask him to have sex with me for the 2nd time. I was used to holding George's penis even for the whole night, but Jabu doesn't want me to hold his penis. George allowed me to hold his penis for as long as I wanted and whenever I wanted. But anyway I don't blame Jabu because he is on mental medication. I think medication for mental disability affects sexuality. I can't think of any other reason why a 47-year-old man cannot have sex properly; Maybe, I can only blame the medication that John is taking for schizophrenia. That is all I can say Christine, I just can't think of anything else.</p>
7.	<p>INT: <i>You said you think medication for mental disability affects sexuality. Can you give me a specific example of why you think that way?</i></p>
8.	<p>You see if Jabu takes his medication for mental disability, he just falls asleep. Even though I take a higher dose than him, I notice that he will just sleep, but as for me I don't sleep. I take 9 different types of medication per night; the 10th type is an injection which I get once every month. So every day I take 9 different types of tablets and Jabu just takes one, because I think his system is very weak. He tires very easily. I take 9 tablets, and after that I want sex, Jabu takes just one and he goes off to sleep. I think I take more because I took a long time to stabilise because I became mentally disturbed at age 22. So I remember that they said it took a long time for them to work out what my real diagnosis was. They just knew that I was mentally disturbed but they didn't know how. They tried me on every medication, to find out the one that would work for me, until the now late Psychiatrist overdosed me, but then he died after he had found the correct combination for me, <i>for Bipolar Affective Disorder</i>. So now if I fail to take the 9 tablets, I just go into relapse and I can start to break windows or walk around while I am naked. The psychiatric doctor died of heart attack in 2007, but I also think that he was a drunkard. But with Jabu I am giving him sexuality training, he really needs it Christine, because in his whole life he just slept with a prostitute once before me. I am just hoping Jabu will get there. I like Jabu because ever since I met him, I have been better mentally. Although Jabu is schizophrenic, he keeps me going. When I was alone, I used to rewind my whole life and then I would get depressed. I would think of George and look at his picture, wondering why he left me. If I wear a nice night dress, I would start thinking that if George was here, he would have said "you look beautiful". So sometimes I would get into relapse if I start thinking about George, so I see that Jabu has really changed my life because I don't get depressed that much. He is not good with sex but I think I am better off with him than alone, I am a much happier person now and the little bit of sex we have is not bad. I know it will get better with time. It's better than being alone and lonely and depressed.</p>

	NO.9
1.	INT: <i>You said you had two other boyfriends. Do you remember any particular incident about that time when all that was happening?</i>
2.	<p>The first one was Tonde. He was a married man, and he was married to a Student Nurse. Tonde was the founder of some computer company, but I have forgotten the name of the company. But I want to tell you the truth, when George was womanising, that is the time that I started to have an extra-marital affair with Tonde. Let me not lie to you Christine, this relationship did not start later; it started when I was with George. It was a relationship that I had with Tonde when George was still in the house with me as my husband, although our relationship had gone bad. I met Tonde when he had come to drop off his student nurse wife at <i>Harare Hospital</i>. I had finished duty at 8 at night and I was now walking along the road from the hospital, trying to get transport to get home. So I stopped Tonde's car and I said "where are you going" and he said "I will take you where you want to go because you are a Queen". I said "I am going to <i>New Marimba</i>", and then he said "where do you work" and I said "I work at <i>Harare Hospital</i>". So he said, "jump in and I will take you home". He introduced himself to me and told me that he had a company for computers, I also told him that I was doing a computer course and I asked for books and he said ok! I will give you. That is how the relationship started, he brought me books and sometimes he would pick me up and take me to his company, and we started kissing. I realised that I was now having an extra-marital relationship, but I was bitter because George was also having <i>small houses</i> (mistresses). So now the situation of my marriage was that George was having extra-marital relationships and I was also having mine. Tonde liked outdoor life, so we would travel in the countryside and we would touch and kiss. I would lie to George that I was going for a professional workshop, then I would go for a braai with George and he would buy me groceries to take home and I would lie to George that my brother was buying me those things. Tonde knew that I was married but he didn't mind. I just didn't tell him that I had a mental problem, because I notice that able bodied men are not very happy to associate with mentally challenged women. One day he dropped me off and we got inside my house together, George was there and I introduced Tonde as a former school mate and George believed it. Tonde also introduced me to his wife as a former school mate. So whenever we ran out of money, George would say "why don't you borrow money from Tonde your former school mate", so I would borrow from Tonde and when it comes time to return the money, we would go to Tonder's place, together with George to repay. So I just continued to see Tonde until his company got broke and closed down. We lost touch, but later I phoned his house and the wife told me that Tonde had gone to Botswana to try to work there, because the economy in Zimbabwe had gone very bad. Then after Tonde, I started to date Chuma. I dated Chuma for a long time, but I don't know what he was thinking of because he never talked about marriage. Those are my two boyfriends Christine and I think that's all that I can just say.</p>
3.	INT: <i>You said then after Tonde, you started to date Chuma. Do you remember any particular incident about that time when all that was happening?</i>
4.	I remember that I met Chuma in a queue. You remember those days when there was no cash in the banks and people would queue for the whole day and sometimes be told at the end of the day that the bank didn't have money. Or sometimes you wait for a whole day and when your turn comes they will say there is no electricity so our

	<p>computers are not working. So I met Chuma whilst we were in the queue in Sam Levy and he remembered me as a nurse. We spent the whole day waiting in a queue for our turn to get into the bank, so we were just talking. He said I had nursed him when he was suicidal and when he had tried to commit suicide. He showed me a gunshot wound that he had come with to hospital, because he had tried to shoot himself because he was having marital problems with his wife. At that point, I remembered him and I remembered that as a psychiatric nurse I had nursed him in 2001. I was counselling him so that he could become mentally stable; although I had my own mental problems and I was taking my medication I was also trying to help Chuma. So he said "I am sorry I heard your whole story that your husband ran off with a <i>small house</i> and left you". After that Chuma started to visit me and he would say "hi Mayita" and I would say "hi Chuma", and so we would chat and a love relationship developed. Then we started to have sex, we did everything but not to the standard I reached with George. Chuma didn't want to lick my vagina. But you see Christine the problem that I saw was that Chuma was like Jabu in one way. He wanted me to suck his penis but he didn't want to lick my vagina. I don't know if Tonde would have sucked me, because we never really got to have sex, we were just touching and kissing. But Chuma was good with sexuality but definitely he would not get to the standard of George. No one can beat George. Chuma was good but he can only be better than the one I have now, this Jabu, but to be better than George, No! George was good with sex. I don't know why but since he is not a Black man, I think that maybe he was watching films about sexual things, but I never saw George watching the film but I am just suspecting, because I don't know how he could have learnt all those nice things about sexuality. I see that Black people are hesitant; they don't go all the way like George. But anyway, George hurt me so I don't want him anymore. Now I love Jabu, but the only problem is that I think Jabu is like Jesus Christ. I can just tell you Christine, Jabu is just like Jesus Christ.</p>
5.	<p>INT: <i>You said now you love Jabu but the only problem is that you think Jabu is like Jesus Christ. Can you give me a specific example of why you think that way?</i></p>
6.	<p>He doesn't complain. Even when I was in love with Chuma, Chuma would come when Jabu was there and Jabu would just keep quiet and wait to talk to me when Chamu was gone. I keep pictures of George on my wall, but Chamu doesn't complain. He is just a person who doesn't complain about anything, I think he is just like Jesus Christ. But I would have married Chuma but he took long. I think he doubted the relationship, imagine 6 years. You see it's a problem Christine if a woman is mentally disturbed, so I think Chuma doubted because he got to know that I live with a mental disability. So he didn't want to talk about marriage. We would just have sex, but you see I like marriage because I think marriage stabilises a person. But you know when you have a mental disability; people find it hard to take you seriously, they just think you are a mad woman. You know even for George, I suspect that he left me because of my mental disability. Because imagine he said he didn't want more than one child, but he ran off with a small house and now he has 2 more children with that woman. So I suspect that the issue between me and George was not about children, but it was because he got tired of marrying a mentally challenged woman, because sometimes when I get into relapse, it's not easy because I can say or do anything. And you know maybe his friends were saying how can you marry a mad woman. So I think the same for Chuma also, I think he didn't want to commit to me because he was now knowing about my mental problems. So people fear that if I go into relapse I may harm them. But you see Jabu is like Jesus Christ because if I go into relapse I can go for a whole month without bathing. If he gives me clean</p>

	<p>clothes I refuse, I just wear that same dress throughout the month, and no one can make me bath. If its menstruation then Jabu just puts a pad in my pant and if it's wet with blood, he just takes it and throws it away and puts another one, but I will not bath. Jabu doesn't complain. He understands me because he is also mentally challenged. Relapse can go for a month and I will bath after one month. With mental disability, relapse comes in many ways. You never really know what will happen until it happens.</p>
7.	<p>INT: <i>You said with mental disability relapse comes in many ways. Can you give me a specific example of how relapse comes?</i></p>
8.	<p>I can just get angry and I start to break things or windows or to beat up people. Then when that happens they have to forcefully take me into mental hospital for treatment that suppresses my violence. Or I can go into relapse and just keep quiet and I don't want to bath and I just sleep in my room for a whole month without bathing. Or I can just be very rude. One day I went into relapse and I was in our rural village and there were lots of people at my father's compound. Then I said to my father "I want to go to Harare". Then my father said "what do you want to go to Harare for, you can't go to Harare because you are sick", then I said "I want to go to Harare to have sex with George, I miss George's penis, I am thinking of George's penis because my vagina doesn't take any other penis, I don't know about you father maybe your penis takes any vagina, but my vagina takes George's penis only". My father was so embarrassed because there were many elderly people at the homestead and as you know open sexual talk in African culture is forbidden. Everyone blamed my father for trying to talk to me in the presence of people when he knew that I was mentally disturbed. With relapse, sometimes I can just take off my clothes and start bathing myself naked even in front of my father or other men without even a piece of shame, or I can just shout at people for no reason and become very violent. I think relapses are a big problem for a spouse if you are married. I can just say relapses can make life very difficult Christine.</p>
9.	<p>INT: <i>You said you think relapses are a big problem for a spouse if you are married. Can you give me a specific example of why you think that way?</i></p>
10.	<p>Like one day George bought groceries for me and bought bus tickets for me and the children to go and visit my in-laws. I stopped the bus and I took my children and the groceries and we started to go to my own parents. So when the Blue Arrow bus got there, my in-laws were waiting at the bus to pick us up, but we were not there. So they phoned George to say "we have not seen Mayita and the children but you said you put them on this bus". They were angry with George thinking that he had lied to them, but George knew there was a problem and that maybe I had gone into relapse. So he started to look for us until he got to know that I had changed route somewhere along the way, because when he asked the bus people they told him that I had gotten off with the children, saying that I now want to board a bus to my parents. You see the people in the bus would not know that I have a mental disability because it doesn't show; they just thought that I am a normal mother who knows what she is doing with her children. Because my disability doesn't show, people respect me a lot but once they know that I am mentally challenged then they begin to have their doubts. So George had to follow me to check on me and the children. He knew that my people didn't quite like him, but he didn't have a choice, he just got there and they refused to allow him to see me. When I got there I started to take off my clothes and bathing naked in full view of everyone, so they knew I had relapsed. They blamed George for putting me on the bus on my own with the children when I was mentally disturbed. So maybe my mental problems are the reason why George left me, maybe</p>

	he was tired of my mental relapses. I think George is doing fine with the children in South Africa. I don't talk to them but I just think. These are the things that I hear Christine so I can just say they are fine.
11.	INT: <i>You said you think George is doing fine with the children in South Africa. Can you give me a specific example of why you think that way?</i>
12.	I heard that my first daughter is at the University. I think she is now in 3 rd year, but I don't know what she is doing. I know she is studying, but I don't know for what. My 2 nd daughter is also now in University. I don't talk to my children but my brother talks to them. He is the one who tells me all these things. He also told me that my daughters are in touch with their relatives from the father's side including George's parents. From my family's side, my children they just talk to my brother only. George, I don't talk to him, he doesn't look for me and I also don't look for him. Now I have just put my eyes on Jabu. Although George is a White man, I think he likes African women too much. Even when he was womanising in Zimbabwe, George was not womanising with White women, he would always go for Black Zimbabwean women. I think George is just a strange character.
13.	INT: <i>You said although George is a White man you think he likes African women too much. Can you give me a specific example of why you think that way?</i>
14.	He always said African women are beautiful. He loved my labia and he would say "white women are not beautiful. He would say, truly African women are beautiful. While he was fondling my labia, I used to hold his penis like a telephone handset. Even though I am disabled our sex was very well with George. He liked my pulled labia and he would say that White women they don't pull their labia so they are not beautiful. Even the woman that George is living with in South Africa now, she is a Black Zimbabwean woman. He took her from here, in Zimbabwe. I think she also pulled her things. George enjoyed touching my labia and sucking them and he would say that if he plays with them he feels a special feeling on his penis, and he would say "truly African women are beautiful". I pulled my things when I was still a young girl. Vanatete vakati (aunts/father's sisters) said "if you don't pull you will be like a bottle without its neck and your husband will have a plain and boring vagina and he will leave you for other women who would have pulled". So they gave us the concoction for pulling; they burnt the leg of <i>jongwe</i> (cock/chicken). They burnt that leg of the chicken to ashes then they mixed the ashes with vaseline and gave us in little plastic bottles. So we would take this stuff and use it to pull. Me I couldn't pull to the required size of the middle finger but I pulled up to this level (half way of middle finger). All the men I have had sex with loved my pulled labia. I also told my daughters to pull, but my first born daughter said "mummy why should I do this rubbish of yours, I am not going to do such rubbish", and I said "what are you going to do when you get married because your husband will leave you if you don't pull?" and she said "who told you that I want to get married, I don't want to get married". She refused so I just left her like that, but my 2 nd daughter agreed, so I taught her and she pulled. But you see I spent another short time with a boyfriend also. Sorry Christine I had forgotten to tell you about this boyfriend. But it was not a very long time; it was just a very short time.
15.	INT: <i>You said you spent another short time with a boyfriend also. Do you remember any particular incident about that time when all that was happening?</i>
16.	I just loved him for a short time, I think just 4 months. He was boring, he didn't kiss, and he didn't touch. He just wanted penetrative sex. Even during sex he didn't even groan and he would ejaculate very quickly. He was just lifeless. He would not say anything during sex, you know even to whisper nice things in my ears to show that he

	<p>is enjoying. There was no touching or anything, he just wanted penetrative sex. So I tried for 4 months then I gave up. He was not married but surely he was not a good lover. I think that if you are disabled and you are a woman you are disadvantaged. I think there are just some things that disabled women cannot have Christine. That's just all I can say, because I have seen that life is not easy for a disabled woman, because of what I go through and also what my disabled friend goes through.</p>
17.	<p>INT: <i>You said that you think that if you are disabled and you are a woman you are disadvantaged. Can you give me a specific example of why you think that way?</i></p>
18.	<p>I think men will be out to use you. I think this boring boyfriend of mine just wanted sex from me. Even that Chuma guy, imagine I was in a love relationship with him for six years but he didn't want to marry me. If men know that you are mentally challenged, they just want you for sex but not for marriage. So now I am thinking I want to go for a man with a disability that's why I am sticking to my Jabu who is mentally disabled like me. I think love life is better with my Jabu who is schizophrenic. I think George left me because of my mental disability, he just didn't want to say it openly, and so he just blamed me for having a second child. So with Jabu at least we share a similar background. He comes from a poor family and I also come from a poor family. He is mentally challenged and I am also mentally challenged. If today Jabu says "<i>unopenga</i>" (you are mad) I don't mind. He sometimes says it and I also say it to him and both of us say "<i>saka tese tinopenga</i>" (so both of us are mad) and we laugh about it. But if a person who doesn't have a mental disability says "<i>unopenga</i>" (you are mad), I feel angry, and I start to think that they are looking down on me because of my mental problems. Anyway, I have now forgotten about George. I broke the glass in which he kept that cloth with my blood for virginity and I took that cloth of my virginity blood and I threw it away. I just didn't think it made sense to keep it, because George was now gone, so everything became meaningless. Now I am happy with Jabu but sex is a problem. I think Jabu needs help Christine. If you know anywhere where he can go for help I would be happy if you let me know. I think that's all that I can think of.</p>
19.	<p>INT: <i>You said you think Jabu needs help. Can you give me a specific example of why you think that way?</i></p>
20.	<p>You see Christine we are living in a poor country, Zimbabwe has become very poor you know, so if mental drugs come they just give you whatever comes, otherwise there will be nothing, because they don't have money to buy different types. So they don't check if the drugs are disturbing you or not. They just say these are the drugs for everyone with mental disability. So you just take the drugs even if they are disturbing you, because if you don't take them, you will relapse. And for a woman you start thinking that maybe a side effect is better than a relapse. You know Christine if you are a woman, a relapse is not good, because if a relapse comes, I can even take off my clothes and go and sleep in the street while I am naked. So you know what happens to a man's penis if a man sees a woman's naked body, buttocks or pubic hair, he will just get an erection and he will rape me without a care of whether I am mentally challenged or not. So by the time my relapse is finished, I may have been raped many times without me even knowing it, and because the drugs make me love sex, I will just think I am having sex with my boyfriend when I am actually having sex with a rapist. We just take the drugs that we are given at Government Mental Hospital to avoid relapse. But I think that me and Jabu we respond differently to mental drugs.</p>

21.	INT: <i>You said you think that you and Jabu respond differently to mental drugs. Can you give me a specific example of why you think that way?</i>
22.	I think the drugs for mental disability decrease the libido of men because Jabu just struggles with sex. But I think the drugs increase the libido in women because I don't want to lie to you Christine, I love sex. But for my boyfriend Jabu I think it's the opposite. So we have a problem there. I want sex and when I want sex he is just falling asleep from the drugs because they send him off to sleep. If I take the drugs I feel that I begin to want sex too much). Even though I take a higher dose than him, I notice that he will just sleep, but as for me I don't sleep...I take nine tablets, and after that I want lots of sex; he takes just one tablet but he goes off to sleep and he doesn't want sex, but in hospital we are afraid to talk about this problem because the nurses think we don't have sex, so they just give us tablets and injection and we go quietly, but we have a problem of our sex. So maybe the mental drugs we are getting from the Government Hospital are increasing the libido of women and decreasing the libido of men. I don't know for sure, but I think this is what the drugs are doing to my relationship with Jabu. I demand too much sex and Jabu avoids sex. No matter how much I shake my buttocks and rub them against his penis, the guy just doesn't respond. So me and my boyfriend we have a sexuality problem but we can't talk to anyone. I see that Jabu's penis is very big, it's bigger than George's penis, but I see that he has a big penis but he can't use it properly because when he takes his mental tablets, he goes off to sleep. We go for mental injection once every month, and after that we are just given our mental tablets and we go home. The people in this country they don't want to talk about sexuality. I have interacted with a lot of doctors, nurses or counsellors but I have not heard them talking about sexuality. They just talk about my mental problems as if that's the only thing I have in life. They think sexuality is a useless subject but you know sometimes we have our own problems which need to be solved about sexuality but they just think we should focus on solving our mental problems and not our sexuality problems. But as disabled women we realise that we cannot talk about sexuality with people, because people think we don't have it. As disabled women we discuss issues of sexuality with each other when we meet. I think that's just the way life is.
23.	INT: <i>You said as disabled women you discuss issues of sexuality with each other when you meet. Can you give me a specific example of what you discuss about?</i>
24.	We just tell each other that, "ladies when it's time for sex you have to put your crutches aside and forget for a while that you are disabled and you just enjoy yourself, then you can think about your crutches after sex". That's what I tell my friend <i>mai Fafu</i> (Fafu's mother), that if you get a chance to have sex, you must just have it and that's what she tells me also. I would love for you to interview <i>mai Fafu</i> , she is my friend. That one I think you will love to hear her story, because I know she is not shy to tell you. She is disabled with polio and she uses crutches, she doesn't use wheelchair and I always say to her " <i>mai Fafu I think you are a prostitute</i> ". I say so, because she describes openly the size of the penis of her boyfriend and we laugh about it. She is a very strong woman, she is disabled herself and she has two children and both of them are disabled and she doesn't have a husband, she never married. Her children one has a mental disability and the other one is in a wheelchair. I will tell <i>mai Fafu</i> about you and that you are interviewing disabled women about their sexuality, and then I know she will be very happy to talk to you about her love life. I can introduce you to <i>mai Fafu</i> on Monday or on Thursday if you want. That's when I am going to see her. I will phone you when I get to her house Christine then you can come and I can introduce you. I think I have really had a nice day today, and I think

	my friend <i>mai Fafu</i> also, would like to have a nice time with you; I just hope that you will be able to find time to see her. For my story I think that is my full life Christine, from beginning to end.
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END	INT: <i>Is there anything else that you would like to add at this point?</i>
	<p>Thank you Christine for coming to interview me. Thank you for giving me a lot of time to tell you my story. Anyway I have some green mealies, so let us eat together. Also I have prepared place for you to sleep, so you can sleep here and then go to your house tomorrow. After that, if you want to talk to me again just call me, but this phone is giving me problems, so if you fail to get through you just try Mr Dotito, we are neighbours, but his only problem is that he is not a very brilliant man, but you can just try Christine. I want to also introduce you to my disabled friend <i>mai Fafu</i>. But her disability is physical it's not mental; I hope you don't mind interviewing physically disabled women.</p> <p>And also before you go Christine, I want to say sorry I had forgotten to tell you that the date of birth I gave you earlier is wrong. My true date of birth is 9 September, 1966, not 6 September, 1967. The date of birth I gave you is the one on my identity documents, but it's wrong. You know what happened during the time of war in this country, they were fighting and all schools in our home area were closed for a whole year because of the war. I was in Grade 7. So my mother was worried that I was not going to get a place to go to high school because the Form I school would say I am too old, because the schools were very strict with age. I had spent a year sitting at home while people were fighting the war. So they had to move my date of birth forwards by one year, so that my age would qualify me to go to high school. I think it worked because the school did not complain about my age, they just didn't know that I had taken a new birth certificate with a false date of birth. You see Christine, sometimes parents do confusing things. I just tell you a date of birth because it's on my identity documents but I know in my heart that it is not my true date of birth and I begin to feel bad about it. Thanks Christine, I will see you on Monday or Thursday so that I can introduce you to <i>mai Fafu</i>.</p>

Appendix 12: Example of transcript, Sub-session 3

Mayita (Psychosocial Impairment)

BNIM Interview

Interview Date: Saturday 29 March, 2014 (1000hrs-1100hrs)

Transcript SS3

1.	INT: <i>You said your family continued to think that you have been bewitched by people in your village who were jealousy of your success and such witches were causing your mental problems. Do you remember any particular incident about that time when all that was happening?</i>
2.	<p>Ah! Christine, mine is a long story. I remember that my parents came to <i>Ingutsheni</i> Mental Hospital and requested for me to be granted one month leave of absence. They had to ask for leave because with mental disability sometimes you can be in hospital for even one year before they release you. So my parents lied to the hospital people that they wanted to try to live with me, to see if I was now able to live with other people in a normal way in our family at home. The hospital granted me one month leave of absence. They gave me leave, but they considered me to be a person who was still admitted in hospital. The hospital thought that my parents were telling the truth. They didn't know that my parents were just trying to find a way to take me to traditional healers and religious prophets. I was taken to many traditional healers and religious prophets.</p> <p>The traditional healers said that my mental problems were being caused by <i>ngozi</i> (avenging spirit). They said that my grandfathers had killed a man in 1950, a man who had come to live in their village under the African custom of <i>kutema ugariri</i>. <i>(the African traditional custom were a man who doesn't have money to pay lobola for a woman that he loves, stays with the woman's family and works in their village for maybe 5-7 years so that he can be given a wife at the conclusion of the agreed period. In addition to the wife, he may also be given some cattle or other things to help him start a family. He does all sorts of jobs such as herding cattle, ploughing the fields, cutting firewood, going to the grinding mill or any other work that he is tasked to do by the woman's family).</i> The traditional healer said that after the poor man had worked tirelessly for my grandfathers, believing that he would get a wife, they decided to kill him, because they did not want to honour their promise. So the traditional healer said that my mental disability was now being caused by the avenging spirit of that man, which is now coming to say "<i>ko makandiurayirei?</i>" (why did you kill me?).</p> <p>The traditional healers also said that it is the avenging spirit of that dead man that cause the women in my father's family lineage to fail to sustain their marriages. And I think it's true Christine, because in my family even if a woman marries well she is still abandoned by her husband later on, like what happened to me and George. Three of my sisters are now late and all of them died of HIV. My cousin sister married a rich man and they were living well but I just heard last month that they are now divorced. The traditional healer said that, such things are the work of the avenging spirit and I think some of these African things are true Christine, because I don't understand why everyone is having bad luck. And imagine even for me, I knew that</p>

	<p>George loved me with his whole heart, but he left me just like that. I truly believe that my grandfathers killed that man to avoid giving him the wife and cattle that he had worked for, now it's causing us problems of death in the family, disability and divorce.</p> <p>The traditional healers said that there is only one solution; to give a virgin wife to the family of the dead man, so that his spirit can rest and we can have peace in the family, so that the divorces and disabilities can stop. My father's family is still to choose a daughter to use for appeasing the avenging spirit. They faced a challenge because my sisters, I think by the time the traditional healer saw what was happening with the avenging spirit, all my sisters had lost their virginity. I think my sisters were prostitutes Christine, that's why they all died of HIV. So my family believes that it is the spirit of this man which has induced my mental disorder. But George's family believes that it was stress caused by parents when they were refusing for me to marry George.</p> <p>The religious prophets said that my mental disability was caused by witchcraft because when I started working I followed the African custom of buying a blanket for my grandmother from my father's side and also to give her a portion of my first salary. As you know that in our culture, they say if you do this, things will be well for you in the city, because the ancestors will see that you have honoured the grandmother by giving her the blanket. So the religious prophets said that <i>ambuya</i> (my paternal grandmother) and my <i>babamunini</i> (father's younger brother) took that money which I gave to my grandmother and gave it to the traditional healer to use it to cause harm to me. So the religious prophets said that from that time on, that's when I started to have a mental disorder. So they were giving me little stones to put in my bath water and also holy water to mix with my bath water when I bath. They said this was going to remove the witchcraft and the avenging spirit and I will be well again.</p> <p>You know sometimes when you are getting treatment from traditional healers and prophets, you may be asked to go and live at the homestead of the prophet or the traditional healer. I was required to spend days at the homesteads of prophets for treatment. A prophet had sex with me for four months before I went back home. Some prophets demand sex in exchange for healing. So a prophet who was treating me, decided to start to have sex with me. They say "if you want the avenging spirit to go away so that you can be well, you have to have sex with me". I was required to spend days at the homesteads of prophets for treatment. A prophet had sex with me for four months before I went back home. Some prophets demand sex in exchange for healing. They say if you want the avenging spirit to go away you have to have sex with me. He said the "holy" oil he uses to heal can only work if it is applied to his penis and then put in my body through my vagina, because the oil has to go kumuromo wechibereko (to the mouth of the uterus) and he can only do it through his penis. So he puts the oil on his penis, then he puts his penis in my vagina and he says that is the healing for mental disability. I told my family about the treatment method and they said I have to do it, if I want to get well because the prophet takes instructions kunaMwari (from God). Traditional healers also do the same. When I went to traditional healers, I saw that the healers tell men that if they are sick with epilepsy or HIV, they can have sex with a disabled woman and get healed, or if the men want to get rich they should do the same. When my husband left, a lot of men</p>
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	<p>wanted to have sex with me. I think they were trying to get all these things that a traditional healer promises, because these men know that I have a mental disability. They can say that the spirit of the ancestors has told them that they have to penetrate your vagina so that you can get well. So you see, as a disabled woman who is desperate to get well, I may just end up having sex with the healer so that I can be treated. The problem with mental disability also is that everyone in Zimbabwe believes that it cannot be treated at hospital but it is caused by spirits and witchcraft so it can only be treated by traditional healers and religious prophets.</p> <p>The first thing that the traditional healer does when you get there is they will take the mental tablets and throw them in a pit toilet. They will say that if you continue taking tablets you will die. But for me I stayed at one traditional healer's compound for one week and I got into relapse and they took me back to Mental Hospital and when I was stable they also came and took me back to the traditional healer. I remember that one night I woke up and I ran away when everyone was sleeping and I went back to the hospital and I told the hospital people that my parents were taking me to traditional healers who were stopping me from taking medication. But the hospital cannot do anything because they say that is the decision of your family.</p> <p>But you see Christine both the traditional healers and the religious prophets will just say "I think you are very beautiful, I want to marry you". So I can think they are telling the truth, but later I see that they just want to have sex. So I realise that I can just have sex and in the end the healers they don't marry me. But the parents they don't know that these healers are not innocent, if I refuse to go they will say I am being stubborn but sometimes I will have seen that I am just having sex for nothing.</p> <p>I also noted that the traditional healers tell men that if they are sick with epilepsy or HIV/AIDS they can just have sex with a disabled woman and they get healed. They also tell men that if they want to get rich, or for their business to make a lot of money, they just have to find a disabled woman and have sex with her and they will become rich. So you see that a lot of us disabled women get sexually abused because the men will be trying to get all these things that the traditional healer would have told them. But you know "I am not just a woman for sex, even if I have a mental disability, I also want to be loved and to get married, I just don't want to have sex for nothing because if I do that, it's like I am a prostitute".</p> <p>But you know for me and George, I think if his parents were still in the country they would have helped us to stabilise our marriage. Because I remember that on the day that I discovered that George was having a "small house" I phoned them and they drove 500kms to come to <i>Harare</i> to counsel us and to tell George to stop doing that. The only problem is that George's 3 sisters got married and left the country. They are all working and they are all married. George's parents also left the country. So from his family George was the only one who was left in Zimbabwe, so he was now doing his own thing without a care, until he also decided to run off and go to South Africa. When I discovered that George was having "smallhouses", I went into a very bad relapse which lasted for like one month. I was in seclusion for that whole month, when I came out of hospital, I found George gone. He had left for South Africa with his girlfriend, leaving the children on their own. I think maybe he just got tired of my mental relapses, but you see Christine my relapse was not just for nothing. George was a man who had loved me through thick and thin and I never thought he would be</p>
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	<p>unfaithful to me. Above all, he was a Church Pastor. I don't know, but I think if his parents were still in the country I don't think we would have divorced.</p> <p>George was very obedient to his parents he was very scared of his mother especially, so he listened a lot to what the mother said. But now I am getting married to Jabu in April and then in August we are having a wedding at the ZAOGA church in <i>Ruwa</i>. I am going to invite you Christine so that if you are not at your school in Cape Town you can come to my wedding. Jabu has some cattle in his village so he is going to sell them so that he can raise money to pay the bride price for me. Also his younger brother is growing tobacco so when he sells his tobacco in March or April he is going to give some of the money to Jabu so that he can add to his money for cattle and pay the bride price</p> <p>Even though I am a great lover of sex, I think it's better to have it with a man who truly loves me and I know that he is going to marry me like Jabu. Oh! Sorry Christine, I didn't tell you that when we went to Jabu's rural home, when he was going to introduce me there we stayed at his village homestead for one week. And you know this African culture which doesn't allow me to sleep in the same room with Jabu at his parents' homestead before he pays bride price for me. So I was sleeping with his sisters in another hut and John was sleeping in another. I would just lie to his sisters that I am going outside to get some fresh air and I would sneak into Jabu's hut to have sex then I go back to the other hut to his sisters. Honestly, Christine, how could they expect me to go for a whole week without sex? It's not possible. I was just pretending that I am not having sex with Jabu, and pretending to respect the African culture, but the truth of the matter is I wasn't.</p>
3	Do you have anything else that you would like to say
	<p>I want to say that, at first I was thinking that you are like those University people who just come to mental hospital and interview us once and disappear, but I think that your University is different and I see that you are different. I am happy that you have come back because I had forgotten to tell you that now I think I am pregnant and that all my underpants are now torn so I don't have anything to wear for my underneath...Thank you Christine for coming to interview me. Thank you for giving me a lot of time to tell you my story. I have answered questionnaires when I was in <i>Ingutsheni Mental Hospital</i>, and I just marked boxes and I kept my mouth shut. The teachers and students for Psychology at Women's University in Africa, and Midlands State University said they were going to interview me, but they just say we are coming but they never come. I just thought you were one of those University people and their teachers that have lied to me before and disappointed me. I don't know what kind of psychology they are learning, because they said they were studying psychology, but maybe it's not true, because if they were really studying psychology then maybe they would have come. But maybe you are different because you come from Cape Town University. At first, when you gave me that paper and explained to me, I just agreed to 10 o'clock but in my heart I was saying this is another lie. Because you see, if people know I am mentally disturbed, they don't take me seriously, they don't know that I am not always in a mental relapse, and there are times when I can really know what I am doing. Thank you Christine</p>

Appendix 13: Example of data field notes immediately after the interview

BNIM Interview with Mayita (Psychosocial Impairment)

Interview date: Saturday 15 February, 2014 (1100hrs to 1530hrs)

Data Field Notes Immediately After the Interview SS1 & SS2

- Interview lasted four and a half hours
- Long interview
- By the end of it I was exhausted
- She loves talking about her life story
- Promises to tell the truth
- Thinks that impairment medication increases her libido
- Says she is a great lover of sex
- Disappointed with boyfriend's low libido
- Thinks impairment medication decreases boyfriend's libido
- She bemoans her current sexual dissatisfaction
- She looks beautiful
- Planning to marry her boyfriend Jabu
- Believing that Jabu will get better at sex
- Cohabiting with boyfriend, Jabu
- Ex-husband deserted her
- She suspects it was because of her perpetual mental relapses
- Doctor struggled to articulate proper diagnosis for her mental impairment
- Diagnosed with Bipolar Affective Disorder
- Despite his low libido, she is happy to have Jabu in her life
- She wants to develop on-going relationship with me as the researcher
- She wants me to interview her friend who is physically impaired with polio
- Explicitly describes details of her experiences of sexuality
- Bemoans silences surrounding issues of sexuality in Zimbabwe
- Disappointed with the fact that doctors, nurses and counsellors; they all don't want to talk about issues of sexuality
- She has not found assistance within healthcare delivery system, regarding the challenges she is confronting in relation to her sexual experiences with Jabu, her current boyfriend,.

Appendix 14: Example of polished notes

Mayita (Psychosocial Impairment)

Polished Notes, SS1 and SS2

Interview Date: Saturday 15 February, 2014- 1100hrs to 1530hrs

1. Born 6/09/1967
2. In poor family of 10
3. Shy child
4. Went to boarding school
5. Started menstruating in Form 3
6. Menstruating/wanting opposite sex INCIDENT/TIME?
 - 6a) Met man called Chuma
 - 6b) Love relationship developed
 - 6c) No kissing/touching/sex
 - 6d) Relationship died
 - 6e) School of Nursing
 - 6f) I was taught about sexuality
 - 6g) I received Jesus Christ
 - 6e) I kept church rules INCIDENT/TIME?
 - 6e1) Kept myself pure
 - 6e2) Fell in love with Tonde
 - 6e3) Refused kissing/touching/sex
 - 6e4) Broke up with Tonde
7. I met my former husband INCIDENT/TIME?
 - 7a) He was a student Pastor
 - 7b) A perfect believer
 - 7c) No sex/kissing/caressing
 - 7d) Prepared for customary marriage
 - 7d1) It was in 1989
 - 7d2) My parents refused marriage
 - 7d3) George is European/Indian descent
 - 7d4) Problems mounted INCIDENT/TIME?

7d41) George's parents refused marriage

7d42) I am Black African

7d43) I broke down

7d44) I became mentally disturbed INCIDENT/TIME?

7d441) Parents shocked

7d442) Rebellious

7d443) I broke things

7d444) Shouted at people

7d445) Took off my clothes

7d446) George loved me a lot EXAMPLE/THOUGHT?

7d4461) Now a mad woman

7d4462) *Gokwe* District hospital

7d4463) Transferred to *Gweru*

7d4464) Diagnosed with mental disorder

7d4465) Things just started to change INCIDENT/TIME?

7d44651) His sisters condemned parents

7d44652) Parents asked for forgiveness

7d44653) I was mentally unstable

7d44654) Relationship began to change INCIDENT/TIME?

7d446541) Weekend with his parents

7d446542) Got new dresses

7d446543) Got new night dresses

7d446544) Families counselled

7d446545) God smiled at families INCIDENT/TIME?

7d4465451) Discharged from hospital

7d4465452) Now with mental impairment

7d4465453) George's parents paid bride price

7d4465454) Wedded in 1992

7d4465455) Started trying sex INCIDENT/TIME?

7d44654551) Broke virginity

7d44654552) My honeymoon suitcase

INCIDENT/TIME?

7d446545521) I packed soft small cloths

7d446545522) Wipe husband's penis

7d446545523) He wiped my blood

7d446545524) He kept that cloth

7d446545525) I was 26 years old

7d446545526) Sharing sexuality INCIDENT/TIME?

7d4465455261) Medication for mental problems

7d4465455262) Travelled to have sex

7d4465455263) Greatest lovers of sex

7d4465455264) Sexuality on full time basis INCIDENT/TIME?

7d44654552641) George washed my body

7d44654552642) Including vagina

7d44654552643) I washed George's body

6d44654552644) Including his penis

6d44654552645) Groan with pleasure

6d44654552646) With pleasure

6d44654552647) Tongue inside my vagina

6d44654552648) I sucked his nipples

6d44654552649) He would ejaculate

6d44654552650) I got pregnant

6d44654552651) They were not fussy INCIDENT/TIME?

6d446545526511) Ingutsheni hospital

6d446545526512) My mental disorders

6d446545526513) Pregnancy continued INCIDENT/TIME?

6d4465455265131) I liked sex a lot

6d4465455265132) I love sex

6d4465455265133) Having too much sex

6d4465455265134) Waters broke INCIDENT/TIME?

6d44654552651341) Blood pressure high

6d44654552651342) Had sex in hospital

6d44654552651343) Delivered daughter

6d44654552651344) Happily married

INCIDENT/TIME?

6d446545526513441) George's family visited

6d446545526513442) My family visited

6d446545526513443) Focused on love with
George INCIDENT/TIME?

6d4465455265134431) Penis / telephone handset

6d4465455265134432) Second pregnancy

6d4465455265134433) Sexuality went wrong

6d4465455265134434) Many problems INCIDENT/TIME?

6d44654552651344341) He said I had been foolish

6d44654552651344342) He started to treat me badly

6d44654552651344343) He never forgave me EXAMPLE/THOUGHT?

6d446545526513443431) Started to have *small houses*

6d446545526513443432) Began to hate me INCIDENT/TIME?

6d4465455265134434321) No more a Pastor

6d4465455265134434322) Runs away with *small house*

6d4465455265134434323) Saw George again in 2005

INCIDENT/TIME?

6d44654552651344343231) He Left for South Africa in 2000

6d44654552651344343232) I decided to change things

INCIDENT/TIME?

6d446545526513443432321) Sent children to George

6d446545526513443432322) I retired on medical
grounds

7. George in South Africa

8. Don't think I miss George EXAMPLE/THOUGHT?

8a) I have Jabu

8b) Jabu's penis

8c) I love sex

8d) Jabu doesn't have experience

8e) Jabu doesn't lick vagina

8f) Jabu has problems EXAMPLE/THOUGHT?

8f1) He is schizophrenic

8f2) He attempted suicide

8f3) We do disorderly things EXAMPLE/THOUGHT?

8f31) He has no sexuality experience

8f32) He slept with a prostitute

8f33) Medication for mental disability EXAMPLE/THOUGHT?

8f331) He falls asleep

8f332) His system is weak

8f333) Psychiatrist overdosed me

8f334) For Bipolar Affective Disorder

8f335) Psychiatrist died

8f336) Now better mentally

8f337) He is schizophrenic

8f338) But keeps me going

8f339) He is not good with sex

8f340) But I am better off

9. I had two other boyfriends INCIDENT/TIME?

9a) Met Tonde

9b) He was married

9c) It was an extra-marital affair

9d) Tonde went to Botswana

9e) Started to date Chuma INCIDENT/TIME

9e1) Met in a queue

9e2) He had tried to commit suicide

9e3) He showed me gunshot wound

9e4) I remembered him

9e5) Love relationship developed

9e6) Started to have sex

9e7) Wanted me to suck penis

9e8) Good with sexuality

9e9) But not better than George

9e10) Now I love Jabu

9e11) John is like Jesus Christ EXAMPLE/THOUGHT?

9e111) He doesn't complain

9e112) They think you are mad

9e113) My mental problems

9e114) People fear relapse

9e115) Fear I may harm them

9e116) With relapse I don't bath

9e117) Relapse comes in many ways EXAMPLE?

9e1171) I can just get angry

9e1172) I break things/windows

9e1173) I beat up people

9e1174) I go into mental hospital

9e1175) I can just keep quiet

9e1176) I can take off clothes

9e1177) I shout at people

9e1178) Problem if you are married EXAMPLE/THOUGHT?

9e11781) I changed route

9e11782) Went to the village

9e11783) I took off my clothes

9e11784) They blamed George

9e11785) George left me

9e11786) In South Africa EXAMPLE/THOUGHT?

9e117861) 1st daughter in University

9e117862) 2nd daughter going to University

9e117863) George likes African women

EXAMPLE/THOUGHT

9e1178631) Likes pulled labia

9e1178632) Mistress is Black Zimbabwean

9e1178633) Spent short time with boyfriend

INCIDENT/TIME?

9e11786331) He was boring

9e11786332) He didn't kiss

9e11786333) He didn't touch

9e11786334) Wanted penetrative sex

9e11786335) Disabled woman

disadvantaged EXAMPLE/THOUGHT?

9e117863351) Men use you

9e117863352) Chuma didn't marry me

9e117863353) George divorced me for disability

9e117863354) Jabu is mentally disturbed

9e117863355) I am mentally disturbed

9e117863356) Jabu needs help EXAMPLE/THOUGHT?

9e1178633561) Zimbabwe is poor

9e1178633562) They don't have money

9e1178633563) Side effect better than relapse

9e1178633564) Man get an erection

9e1178633565) He will rape me

9e1178633566) Respond differently to drugs EXAMPLE/THOUGHT?

9e11786335661) Drugs decrease men's libido

9e11786335662) Drugs increase women's libido

9e11786335663) Jabu falls asleep with drugs

9e11786335664) He can't have sex

9e11786335665) I want too much sex

9e11786335666) Opposite with Jabu

9e11786335667) People don't talk about sexuality

9e11786335668) Think it's useless subject

9e11786335669) Disabled women meet & talk EXAMPLE?

9e117863356691) Put crutches aside

9e117863356692) Enjoy yourself

9e117863356693) Interview my friend

Appendix 15: Example of data field notes whilst writing polished notes

Mayita (Psychosocial Impairment)

BNIM Interview

Interview date: Saturday 15 February, 2014 (1100hrs to 1530hrs)

Data Field Notes Whilst Writing Polished Notes for SS1 & SS2

The answer to the SQUIN was one and a half pages. I was only able to extract 4 sentences that I could pursue for PINs in SS2. However, deep and new information emerges in SS2 for example the emergence of her mental breakdown, the breaking of her virginity, her pregnancies and child birth experiences, her great love for sex and her extra marital affair, among other things. There is a lot that can be gained in pushing for PINS, because it is only then that the full story begins to emerge and to make more sense. Pushing hard for PINs in No. 7 of SS2 yielded a lot of relevant information. Mayita appeared to be very happy with being continuously prompted to give PINs. She seemed to cherish the opportunity of being asked questions that gave her a chance to keep telling her story. Mayita is able to tell her story from the time she was born up to her current relationship with boyfriend Jabu. Cue phrases are useful in helping me as the researcher to frame questions that enhance the ability to solicit relevant, deep and rich answers in SS2. Explicit details of sexuality emerge in SS2.

Mayita was happy to answer all the PIN seeking questions although sometimes she would give a narration which is not directly linked to the PIN question. For example, on point 7.29 of SS2, I intended to capture the intimate details of her breaking waters of childbirth during a sexual act, but she didn't answer this question directly, but she still gave a narration of how she had spent a week in hospital due to high BP and having sex with George in hospital. Another example is point 7.31 of SS2; I wanted to capture Mayita's description of her happy marriage in so far as it related to the two of them, herself and George as husband and wife, but again she gave a narrative of George's family visiting and her own family visiting without giving explicit details about the direct marriage relationship between the two of them. Mayita was ready to answer all questions and even after a 4.5-hour-long interview (SS1 & SS2), she was sad that I was leaving. She offered me green mealies, groundnuts and water to drink. She also wanted me to spend the night of that day at her place of residence and to only leave the following day. I had not prepared for the offer so I courteously and tactfully declined.

Appendix 16: Example of data field notes whilst writing up the transcript

BNIM Interview with Mayita (Psychosocial Impairment) Interview Date: Saturday 15 February, 2014 & 29 March, 2014 Data Field Notes Whilst Writing Up the Transcripts

It seems Mayita suffered insurmountable trauma which led to her contemplating suicide when her father refused to grant her permission to further her education. The decision by her father signals the African male child preference syndrome, under which the male child is regarded as a symbol of upliftment of a man's clan and the girl child is looked down upon, as a child who is raised to become a husband's property and to assume her husband's name upon marriage. Mayita suffers further trauma when her parents, and her boyfriend's parents, refused to allow her and George to get married, citing cultural differences. This development seems to have led to her mental breakdown. Intersection of race, gender, culture, and disability.

Mayita was taught about sexuality at the School of Nursing. The school underscored the fact that "every able bodied person has a life of sexuality". Such a proclamation excludes disabled people from sexuality experiences, thereby reinforcing the myths and stigma surrounding the sexuality of disabled women. That kind of teaching to a student nurse may result in Mayita developing a negative attitude towards disabled women that she would interact with in her healthcare work, particularly disabled women who exhibit signs of sexuality consciousness. She may perceive them as being deviant and stubborn and yet no human being is asexual.

Most of Mayita's experiences of sexuality before marriage signal an intersection of culture, religion, gender and sexuality. Religion seems to have had a powerful influence on most of the decisions she made about her sexuality prior to her marriage to George. No sex, caressing, touching or kissing before marriage. She considered the addressing of her sexuality with an intimate partner before marriage as a sin against God and she religiously followed church rules. Consequently, she was able to keep herself "whole and pure" and maintained her virginity until marriage. Whilst maintaining her virginity, she engaged in the African feminine sexuality practice of pulling her labia; a female genital organ intervention practice that is meant to enhance the ability of an African woman to enhance her husband's sexual enjoyment upon marriage.

George applauds the virginity of Mayita and preserves the cloth of her virginity blood in a glass. Such a move reinforces the notion that feminine virginity is a highly prized possession in Zimbabwe, but not only for non-disabled women, but for disabled women as well. In resonance with most African societies, Zimbabwean society scowls at women who lose their virginity before marriage, regarding such women as morally suspect. However, Mayita underscores her own virginity and keeps silent on George's virginity in resonance with a Zimbabwean society's tradition, which applauds the virginity of women before marriage, whilst maintaining silence on the sexual relations of men before marriage, thereby using a model that seeks to leave patriarchy undisturbed. Intersection of disability, culture, gender and sexuality.

Disabled women often encounter great difficulty in securing marriage partners. However, in the case of Mayita she was able to acquire a marriage after her disability, but sustaining the marital union proved to be difficult. Despite the fact that George was aware that his wife is mentally challenged, their marriage altered when George started to engage in extra marital affairs, thereby disregarding how such behaviour would impact on his wife who is mentally challenged. Consequently, Mayita experiences increased incidences of relapses and George doesn't seem to care. When she had a bad relapse which resulted in her spending almost a month in seclusion at the Mental Health Hospital, her husband deserted her and ran away with a *small house*. By the time Mayita left hospital, she found her husband gone, leaving the children on their own. In spite of the fact that they are legally married, George left for South Africa to start a new life with his *small house*. *Small houses* have become a common feature in Zimbabwe, in a scenario which is threatening to replace the formal polygamous marriages of pre-colonial times. George's involvement with *small houses* indicates that compared to their non-disabled counterparts, disabled women also face the challenge of competing with mistresses to sustain their marriages. Gender, sexuality and disability intersect to create a disabled woman's oppressions.

Mayita suspects that George deserted her because of her psychosocial impairment. Whilst she believes that at the beginning, George loved her with his whole heart, she suspects that he eventually left because of her mental relapses. She states that it is difficult for a disabled woman to sustain a marriage or love relationship, with a non-disabled man, given that her non-disabled husband left her and her non-disabled boyfriend Chuma found it difficult to commit to marriage. She attributes such a scenario to a discovery made by Chuma that Mayita has a psychosocial impairment. However, Mayita believes that marriage will give her mental stability and she is contemplating settling in marriage with Jabu. Although Jabu is Schizophrenic, Mayita believes that a disabled man is her best possible option, given that non-disabled men (except for George) seem to just want her for sex and not for commitment. She believes that she and Jabu have a lot in common, given their poor family backgrounds and the fact that both of them have psychosocial impairment – Mayita has Bipolar Affective Disorder and Jabu is Schizophrenic.

At the time of her marriage, Mayita was already living with a mental disability but she talks about a great life of sexuality which she shared with her husband, George, and she reveals explicit details of her experiences of sexuality. When her relationship with George was falling apart, she sought to address her sexuality through an extra-marital affair. Although her husband George deserted her, she still sought to address her sexuality through boyfriends and currently with her boyfriend Jabu. She clearly compares her experiences of sexuality with one man against another, thereby indicating that she knows exactly what she wants and what she expects from an intimate partner relationship. She denigrates the boring and cold boyfriend of 4 months. Although Jabu seems to be struggling to satisfy Mayita sexually, she acknowledges that ever since she met Jabu she has stabilised mentally and she no longer rewinds to her past life of addressing her sexuality with George; thereby reducing incidences of her mental relapses. Mayita professes her great love for the moments she addresses her sexuality in a heterosexual union and she underscores the fact that she loves sex. Such a confession illuminates the fact that disabled women are sexually active and are therefore not asexual beings.

Mayita bemoans the negative effects that drugs for mental impairment seem to be having on her relationship of sexuality with Jabu. She suspects that the drugs are taking a toll on Jabu's libido and to the contrary, increasing her own libido. However, she notes the absence of a

reference point for consultation regarding the challenges she is currently facing in the area of her sexuality. She bemoans the silences surrounding issues of sexuality in Zimbabwe and notes that healthcare staff takes a narrow medical focus on her mental problems, oblivious of the fact that mental drugs may have side effects that may include a negative impact on her experiences of sexuality and those of her partner. She suspects that the effects of the impairment drugs are responsible for the “disorderly sexuality things” that she and Jabu are practising. Treatment and rehabilitation modes seem to be blind to the importance of issues of sexuality to a disabled woman; an area that she considers to be a zone of her greatest oppression.

Mayita acknowledges that her invisible disability is an advantage, given the fact that she is taken seriously in circles where people do not know that she has a psychosocial impairment. However, once people get to know that she has a mental disability, they seize to take her seriously, dismissing her as a mad person. Consequently, men tend to reserve her for sex but not for serious marital commitment. She can therefore only ride on her advantage of invisible disability on a temporary basis as she is likely to experience stigma and marginalisation once her condition is revealed.

She is proud of the fact that she managed to pull her labia to half the size of her middle finger thereby making herself a beautiful and complete African woman. In addition, she is proud of the fact that all the men that she has been sexually intimate with seemed to have fallen in love with her pulled labia, particularly her husband George. Such a scenario indicates that disabled women are not free from the traditional practices that demand female genital organ interventions. She entices her daughters to pull their labia against a belief that such an intervention will enhance their ability to address the sexuality of their husbands upon marriage, thereby reducing the risk of them being abandoned by such husbands. It seems Mayita is oblivious of the fact that in spite of her pulled labia she has been deserted by her husband and she has also broken up with her previous boyfriends. Such a scenario could signal the fact that sexuality for an African woman goes beyond the pulling of labia and perhaps it is not the only asset that a Zimbabwean woman needs to possess in order to maintain a marriage or intimate relationship in a heterosexual union.

The long term nature of impairment allows Mayita’s family to meander through different kinds of diagnosis modes and treatment (religious prophets, traditional healers and contemporary healthcare centres). Such an approach indicates that people’s beliefs about the kinds of treatment or rehabilitation that are likely to work or not work for them, are largely influenced by their cultural backgrounds and perceptions of the world. In post-colonial Zimbabwe, Africans believe that there are just some things that contemporary healthcare centres cannot fathom. Consequently, Mayita is taken out of hospital under the guise of “leave of absence” against a belief that her mental challenges need the prowess of either a traditional healer or a religious prophet. Such a move is associated with the belief in Zimbabwean society, that people who suffer from mental impairment are facing the wreath of an avenging spirit, arising from people whom they killed or where killed by members of their family.

The decision by Mayita’s parents ask the mental healthcare hospital to discharge Mayita so that they could take her to traditional healers and religious prophets is in resonance with the traditional conviction of most conservative Zimbabweans, who believe in the spirit of *ngozi* (avenging spirit). It is believed that an avenging spirit rises from the grave of the deceased to torment the life of the person who secretly plotted the death to bring illness, death or

disability upon him or members of his family. On the other hand, her in laws who are of Indian/European descent were arguing that Mayita's psychosocial impairment was caused stress. The different ways of conceptualising disability between George's parents and Mayita's parents are indicative of the fact that disability does not mean the same thing to all people of all races.

It seems Mayita as a disabled woman living in Zimbabwe is vulnerable to sexual abuse perpetrated by traditional healers and religious prophets. Some of them seem to have a tendency of directly demanding sex in exchange for healing. Others seem to perpetrate sexual abuse to a disabled woman by pretending to have fallen in love with her, and promising her marriage, when all that they want is sex. Others prescribe sex for men who want to be cured of HIV or epilepsy or for getting rich.

Mayita appreciates the interview for giving her a long time to tell her story and the topic of the study for allowing her to talk extensively about her experiences of sexuality, and her great love for sex, an opportunity that she regards as scarce within Zimbabwean disability circles; except for the time that she discusses sexuality with her disabled friends.

Appendix 17: Example of data field notes whilst reflecting on the first three sets of notes

BNIM Interview with Mayita (Bipolar Affective Disorder/Mental Disability)

Data Field Notes Whilst Reflecting on the First 3 Sets of Field Notes

Mayita did not appear to be a promising interviewee in the beginning. I was worried that since she has a psychosocial impairment, it was not going to be easy for me to extract her life story, considering that she forgot about the appointment in the first place and it took me almost an hour of waiting before she was ready for us to start the interview. However, when we finally started the interview she gladly opened up, and I started thinking that the wait was worth it after all. She took the whole interview process very seriously and articulated herself very well. She did not appear to be uncomfortable answering any of my questions. In fact she was prepared to go on and on and on. Mayita appeared free and relaxed to talk, and she was very articulate. BNIM is a powerful technique. I noticed that I was able to push for lots of PINs, which yielded a lot of information which is relevant to my CRQ and TQ. I never thought it was really possible. I think the interviewee made it easy for me because she showed no hesitation in answering any question and also I think I am getting better at pushing for PINs. Mayita appeared to be content with giving me all her time as she appeared to be very composed and not in a hurry to go anywhere.

She gave explicit details of her experiences of sexuality with her husband and boyfriends. She narrates the incidents of virginity breaking, pulling of her labia, her extra-marital affair, her sexuality struggles with her current boyfriend, pregnancy and childbirth issues, sneaking into Jabu's bedroom to have sex at his parents' village homestead. She clearly compares her experiences of sexuality with one man against another, and she openly professes that she is a great lover of sex. Mayita also illuminates the manner in which a disabled woman experiences her sexuality and disability within the Zimbabwean traditional context. She exposes the sexual abuse experiences perpetrated against her by traditional healers and religious prophets. Most of the information she gave is relevant to my CRQ and TQ.

Some PIN questions that appeared trivial, e.g., in point 8.5 of SS2, the issue of "doing disorderly things with Jabu" may have appeared trivial, but the PIN question was able to solicit relevant explicit details of Mayita's experiences of sexuality, comparing her experiences of sexuality between her husband George and her current boyfriend Jabu. It also introduces an important aspect of the manner in which medical drugs can affect the sexuality of a disabled woman. Mayita thinks medication for mental impairment affects sexuality in different ways for men and women. I realise that one can never know what a PIN question may produce until it is asked.

Appendix 18: Synopses of 12 stories that were not included in Chapter 5

Tatenda's narrative of sexual abuse

Tatenda is a fifty-seven-year-old woman who has intellectual impairment. Her biological parents divorced when she was nine months old and when her mother was pregnant with her younger sister. She holds no memories of her biological father, who disappeared without a trace following her parents' divorce. Tatenda was raised by her submissive mother and her alcoholic and abusive stepfather in a family of seven. In a context where it is generally believed that there is no such thing as intellectual impairment, Tatenda was constantly accused by her step-father of being *dofo* (dull in school). She was blamed for not taking her school work seriously and she was constantly beaten up for her failure to read and write. Tatenda's step-father started to have sex with her when she was eleven years old. Apart from breaking her virginity, her stepfather also broke the virginity of her two sisters, including that of her sister who was paralysed waist downwards because of polio. Her mother knew about the sexual abuse but she did nothing about it. By the time Tatenda turned thirteen, her step-father escalated his level of sexual abuse and started to use her as a prostitute. She was made to have sex with a different man each night and her step-father would be paid for the services she rendered. Her step father would take her with him to the pub and leave her standing outside whilst he scouted for male clients in the pub. When Tatenda was eighteen years old, the Government Department of Social Welfare rescued her and her siblings and took them to a children's home in *Gweru*. The home provided her with an escape route from sexual abuse but life at the home was not rosy either. She was hurt as she helplessly watched her siblings being taken into foster homes by different families. Tatenda lost contact with all her siblings. In her later life, she struggled to acquire and sustain a reciprocal intimate partner relationship. Thus far, she has had three intimate partner relationships; one which lasted for two weeks, another for three months and the third one with a physically abusive man who married her when she was 54 years old. Currently living in a mental healthcare institution, Tatenda does not know if her parents or siblings are dead or alive. She hopes to one day be able to meet her siblings and to secure a good man to marry her.

Mara's narrative of rejection and reconciliation

Mara is a forty-two-year-old woman who was born and raised by both her parents in their rural village. At the age of six, her parents sent her to the city to stay with her ***mainini*** (mother's younger sister), because ***mainini*** did not have children of her own. Life was not easy at the four roomed dwelling of ***mainini***, which housed her husband's three wives (including ***mainini***) and several children. Having lost one leg in a car accident, ***mainini*** would rely on Mara to help her undertake most household chores; in her polygamous set up where ***mainini*** was permanently competing with her husband's two non-disabled wives for recognition. Given the size of the family and its limited income, Mara would go hungry on some days as there would always be inadequate food to eat. Tired of hunger, poverty and hard work, Mara began to see marriage as the easiest escape route from such agony. Soon after completing her ordinary level school leaving certificate at the age of seventeen, she married a thirty-year-old divorcee. For thirteen years, she enjoyed a blissful marriage and within the same period of time she birthed three children. At the age of thirty and in 2002, she was involved in a car accident whilst she was travelling with her family to her husband's home village. Mara survived the calamity with a spinal cord injury which relegated her to the use of a wheelchair. Resenting Mara for her acquired physical impairment, her husband branded her a useless woman who was not good in bed. He announced to Mara that he had found ***mumwe mukadzi anogona bonde*** (another woman who is good in bed) and he was therefore moving out of their matrimonial home. It was in 2002, when Mara's husband immigrated with his "small house" (mistress) to their A2 farm which had been allocated to them under the land resettlement programme in year 2000. Six years later (2008), Mara's husband returned, infected with HIV and abandoned by the "small house". Mara welcomed her husband's return and she began to have sex with him, believing that his return was an answer from God to her prayers. She was happy that she was now enjoying the very conjugal rights that she had been denied by her husband and his "small house" for a period of six years. However, two years later (2010) her husband died of an HIV/AIDS related ailment. With an undisclosed HIV status, Mara continues to live in her matrimonial home with her three children and two grandchildren. She is aware that their A2 farm is currently home to their four cows and eight goats, but she is unable to visit the farm, due to a lack of walking aids, transport and funding. Mara intends to find a good man and to remarry.

Rumbi's narrative of resilience

Rumbi is a twenty-two-year-old woman who was born and raised in the city by both her parents in a family of three. She went to a primary school in the city before she attended a boarding high school. She started menstruating and adolescence dating at the age of thirteen. Rumbi lost her sight at the age of sixteen, when she was writing her ordinary level school leaving certificate exams. In what she considers to be a mysterious circumstance, Rumbi went to sleep one night and when she woke up to study the next morning she realised that she had lost her sight. The school headmaster called her parents who came and took her to ***Parirenyatwa*** hospital (major hospital in Harare). She stayed in hospital for six months and she left after leading eye surgeons had failed to diagnose her strange condition. Although her high school boyfriend was sympathetic with her loss of sight their relationship ended when he left Zimbabwe for Australia, to pursue further studies. In their continued search for treatment and rehabilitation, her father took her to traditional healers and religious prophets. She regained her sight for about four hours after she had been prayed for at a church conference but the sight disappeared again when she got home. Rumbi could not go back to her original boarding school because they did not have facilities for visually impaired students. She was subsequently transferred to Waddilove boarding school where she started to learn Braille. After learning Braille she was able to pass her ordinary level and advanced level school leaving exams. She applied for a place to study towards a Law degree at the University of Cape Town (South Africa), after the university had been recommended to her as being disability friendly. However, she got worried that she would not be able to cope with the Cape Town cold weather in winter which threatens to freeze her fingers resulting in her struggling to feel Braille. She therefore applied to study law at the University of Zimbabwe (UZ), and she is currently awaiting the university's response. Whilst she is planning to go to law school the elderly women at her church are setting her up for marriage with a man who has a psychosocial impairment and who often loiters around the church. She noted that with disability, the attitude of society is '***chero chatakurongera***' (whatever we plan for you). Rumbi is reportedly dating a boyfriend of her age who has a partial visual impairment and who is studying office management at a local college. They plan to get married when Rumbi finishes her law degree studies. She is determined to beat her loss of sight by not only becoming one of the leading legal brains in Zimbabwe but by also securing a happy heterosexual marriage.

Saru's narrative of rejection

Saru is a thirty-two-year-old deaf woman whose parents divorced soon after her birth. When she was six months old, her mother left her in the care of her grandmother in the village, as she headed for the city to look for a job. Saru became Deaf at the age of six, after which her grandmother enrolled her to start school at a local village primary school. However, after a fortnight of attendance, the teacher advised her grandmother to deregister Saru from the school citing a lack of facilities for Deaf learners. Her grandmother took her to a traditional healer who used a sharp razor to cut a piece of flesh from below her right jaw and below her tongue. The treatment exercise lasted for three weeks and one day after which Saru and her grandmother were informed that the impairment was incurable. At the age of seven, Saru was enrolled into a boarding school for the Deaf but she spent school holidays with her grandmother in the village. She started menstruating at the age of thirteen and she struggled to manage the cycle because her mother and her grandmother had not educated her about it. She resorted to cutting pieces of her blanket for use during such cycles until another student in school advised her to use cotton wool. She began adolescence dating at the age of fifteen, when she fell in love with a high school boyfriend who was also Deaf. The relationship ended when at the age of sixteen, she was transferred to Emerald Hill School for the Deaf in the city. After completing four years in high school, she went back to the village to live with her grandmother. She returned to Harare at the age of twenty-four to look for employment. She was able to secure a job as a traditional dancer with a local traditional dance group. However, she lost her job at the age of twenty-five when the Chinese man who was leading the dance group died of an unknown ailment and the entity subsequently closed down. At the age of twenty-six, she married a Deaf man who was both a chain smoker and a physical abuser. After three years, the marriage ended in divorce after she had birthed one son. Saru and her son are living with Saru's mother. Believing that disabled men are not good partners, Saru is currently dating a non-disabled man who is still learning to speak sign language. Saru sells sweets and biscuits in order to earn a living. She is hoping to secure a formal job, marry her non-disabled boyfriend and to have more children.

Gamu's narrative of desiring marriage

Gamu is a twenty-year-old orphan who has intellectual impairment. She remembers that her grandfather died but her brother and her grandmother are living in the village. Gamu recalls visiting traditional healers and religious prophets with her family, but she is not clear about the purpose of such consultations. She has not been able to attend school, but she is currently staying at a mental healthcare institution. She bemoans the pain of her menstrual periods and she blames her house matrons for not helping her to mitigate such pain. However, she appreciates the fact that they give her cotton wool to use during such periods. Gamu is currently dating Njodzi, a young man who also has intellectual impairment. She plans to marry Njodzi and to escape institution life by going to live with him and his mother in his village. Standing on a promise of marriage from Njodzi she is fantasising about her wedding. She wants to have children, but she does not want to carry a pregnancy. She believes that pregnancy is proof that she is sleeping in the same bed with a man and she would rather keep such developments a secret, but she finds the practice to be embarrassing. She intends to have two girl children, but definitely not boys because she does not like boys. She asked me as the researcher to help her source for a wedding dress, a wedding cake, food and drink for the wedding ceremony and baby clothes for the two daughters that she is planning to have after marriage.

Tari's narrative of betrayal

Tari is a thirty-eight-year-old woman who has albinism. She was born and raised in the city by both her parents in a family of six. One of her brothers has albinism, but her four other siblings have black skin. In a context where albinism is associated with evil spirits in the maiden family of the mother of the child, Tari considers her mother to be one of the few lucky Zimbabwean women, who was not divorced following her birth and that of her brother. She believes that her mother's marriage was saved by the fact that her father had a dream in which he was told by God that he was going to have a child who would look like a White person. She started dating at the age of eighteen when she engaged in an intimate partner relationship with Tasara who was a soldier. The relationship ended when she was beaten up by Tasara after an altercation. She engaged in another relationship with Itai, a non-disabled boyfriend from her neighbourhood at the age of twenty. Believing in the concept of no sex before marriage, Tari abstained from sex throughout the duration of their relationship. However, Itai used to place his penis outside her vagina without penetrating for a whole year, after which Tari discovered that she was pregnant. Doctors considered this to be one of the rare cases where a woman could fall pregnant whilst she was still a virgin. Upon discovering that she was pregnant, Itai initiated traditional proceedings of marriage that saw them solemnising their marriage both traditionally and in a church wedding. Itai *akabvisa mombe yechimanda*, (gave her parents the cow that symbolises appreciation of the parents of his wife for raising a morally upright girl who is found a virgin by her husband upon marriage). Tari delivered a baby boy (who broke her virginity during the child delivery process). Her husband had not managed to penetrate her vagina throughout the duration of her pregnancy. What followed thereafter was a blissful marriage, in which in some ways Itai was helping to fight the stigma that is associated with albinism. Two years into their marriage, Itai lost his job. However, Tari was able to meet all their living expenses by engaging in various informal business activities such as buying and selling clothes. Their marriage took a negative turn when Tari discovered that Itai was having a "small house" whom he was supporting with money that he was taking from Tari. A few months after this discovery Tari husband died of Meningitis. Their marriage lasted for seven years (2000-2007). Tari lives with her son and she is active in the women's ministry of her local church, and in the disability movement in Zimbabwe. She is currently dating a married man with whom she is addressing her sexuality with. Tari is hoping to find a good unmarried man, with whom she could plan for marriage.

Tamara's narrative of struggling with HIV related ailments

Tamara is a twenty-eight-year-old woman who has partial visual impairment. She acquired such impairment at the age of twenty-three when she reacted negatively to Tuberculosis (TB) drugs after she had been diagnosed with TB and HIV in 2008. She was raised by both her parents in the city, before her mother passed away when Tamara was sixteen. She is disgusted by her father's behaviour who at his current age of seventy-six has impregnated their twenty-two-year-old housemaid and turned her into his "small house" (mistress). Her step-mother is recovering from a TB infection and other ailments and Tamara thinks that her step-mother could now be infected with HIV. She remembers her late mother for her love, and for educating her about menstruation and the importance of pulling her labia. She started adolescence dating at the age of fourteen with her high school boyfriend. The relationship was sustained through writing each other love letters, before it ended when they completed their ordinary level studies at the age of sixteen. Thereafter, Tamara enrolled at a local Teachers' Training College to study towards a high school teaching diploma. She completed her studies at the age of nineteen and started teaching at a government high school in the city. During her teacher training course, she was dating Chada, a Zimbabwean motor mechanic who was working in Botswana at the time. She sustained the relationship by occasionally visiting Chada, with whom she would have protected sex. The relationship ended when she discovered that Chada was cheating on her. At the age of twenty-one, she started dating Gezi, a man who was working as a telephone technician at a local telecommunications company (Tel-one). Whilst standing on Gezi's promise of marriage they started to have unprotected sex. The relationship ended when Tamara was twenty-three years old and when Gezi left Zimbabwe for the UK and stopped communicating with Tamara. Disappointed by Gezi's betrayal she decided to leave Zimbabwe to go and live with her friend in Mozambique. She decided to take an HIV test, after experiencing a relentless tiredness of her body. The results of the test revealed that she is HIV positive. She realised that Gezi had infected her with HIV/AIDS. However, using the skills that she had acquired in Zimbabwe, she started to teach English at a local school before she met her friend's brother, Tawona, who later became her boyfriend. Tawona is HIV positive and at the time of their meeting, he was already on Antiretroviral (ARV) drug treatment. Intent on having their own child, they decided to ignore the advice they had been given at the HIV testing centre. They started to have unprotected sex so that they could achieve a pregnancy. In no time, Tamara conceived and later gave birth to an HIV free son. However, she had to return to Zimbabwe after she was diagnosed

with TB and a serious lung infection immediately after the birth of her son. She reacted negatively to TB drugs and she lost part of her sight. Her weight dropped from 82kgs to 32kgs, and her CD4 count went down to 129. She was admitted to the Intensive Care Unit at **Parirenyatwa** hospital, for two years. The doctors made an effort to boost her immune system, before they could operate on her for the lung infection. She survived the lung infection and was discharged from hospital at the age of twenty-six. She is grateful for the care she got from healthcare staff at **Parirenyatwa** hospital. Tamara lives with her older sister and her son in Harare. Her weight has increased from 32kgs to 62kgs and her CD4 count from 129 to 600. She has not seen the father of her son since she left Mozambique in 2008. She justifies their loss of contact by arguing that Tawona finds it difficult to travel because he is poor and he has polio induced physical impairment. He earns a meagre salary in Mozambique and he uses an artificial right leg which is made of steel, after succumbing to polio at the age of two. She is hoping that Tawona will somehow find a way of getting to Zimbabwe so that he could pay **roora** (bride price) for her. Given the lessons that she has learnt throughout her experiences of sexuality thus far, she recounts that the thing that she now values the most in life is life itself. She feels that HIV stole her joy at a very early age, thereby robbing her of the freedom to address her sexuality in the manner that she would have wanted, given that HIV imposes restrictions on her practices of sexuality. She calls upon those who are not infected with HIV to refrain from engaging in inappropriate experiences of sexuality that may give rise to HIV infections. *“Aids is painful and it can cause you disabilities and other problems, and you can get TB and ARVs can make you get blind. I stayed in Intensive Care Unit for two years and I watched people dying”*. Six themes run through her story: poverty, disability, sexuality, culture, schooling and work, and HIV/AIDS.

Vimbayi's narrative of unanswered questions

Vimbayi is a twenty-two-year-old woman who has Schizophrenia and who was born in a family of six. She remembers that both her parents died when she was eight years old and she underscores the fact that she does not know why they died. Vimbayi was raised by *mainimi* (mother's younger sister) but at some stage she started to live with her brother and again she says she does not know why. Her brother told her that she has a mental impairment and facilitated her admission into a mental healthcare institute. Vimbayi reported that she does not understand why her brother said what he said or did what he did. Vimbayi's brother is a married police officer who beat Vimbayi up after she had had an altercation with his wife. Vimbayi ran away from her brother's house and she started to live in the bush. Her brother found her in the bush and sent her to a mental healthcare institution where she stayed for three months. When it was time for Vimbayi to be discharged from hospital her family was refused to take her home. Vimbayi explained that she does not understand why her family members could not accommodate her after she was discharged from hospital. However, Vimbayi was rescued by a philanthropist who enrolled her into a mental healthcare rehabilitation institution where she has now been staying for two years. She says she dates boyfriends but not for too long. Vimbayi reported that she does not understand why her menstrual cycle is now taking 6 days instead of the 3 days that she used to experience before. Vimbayi would like to get married but at the moment she feels that she is still too young.

Mayita's story of cultural differences

Mayita is a 48 year old woman who has a psychosocial impairment. She was born and raised by both her parents in her rural village in Gokwe and she attended a boarding primary and high school. Mayita had her first intimate partner relationship at the age of 16, but with no physical contact with her boyfriend. The relationship ended at the time when Mayita and her boyfriend left school after successfully obtaining their ordinary level school leaving certificates. After leaving high school and at the age of 20, Mayita enrolled for a general nursing training programme at *Parirenyatwa* Hospital and she started to help her parents and her siblings with the nursing student allowance that she was getting, because they were very poor.

Mayita was in her second year of nursing training, when she started dating George, a young Christian man of Indian/European descent who at the time was a student church Pastor. Their relationship was fashioned around strict Christian principles which directed them not to have sex before marriage. After 4 years of dating they decided to marry and George initiated the process that would see him paying *roora* (bride price) for Mayita. However, their arrangement hit a snag as both their parents refused to bless their intended marital union, citing cultural differences. Traumatized by their parents' refusal to grant them permission to marry, Mayita acquired a psychosocial impairment which saw her family searching for various modes of treatment as her parents tried to rid her of the impairment.

Mayita's parents consulted contemporary health care centres, traditional healers and religious prophets. The traditional healers linked Mayita's psychosocial impairment to *ngozi* (an avenging spirit) of a school child who was killed by Mayita's grandfather in 1950. When Mayita was aged 26 her parents and George's parents changed their minds and decided to allow the couple to marry. Mayita and George got married both traditionally and in church and they went for their honey moon at the Victoria Falls. Her husband made several unsuccessful attempts to break her virginity and he only managed to break her virginity on the 3rd night. Mayita was honoured by her husband when he found out that she was still a virgin at the age of 26. Mayita's husband also appreciated her elongated labia and both Mayita and her husband became great lovers of sex.

It was therefore not long before she fell pregnant with their first child and she gave birth to a baby girl at the age of 27. However, in an unexpected turn of events, Mayita's blissful marriage took a negative turn when 3 years later, she fell pregnant with their second child. Mayita's husband was disappointed when he discovered that Mayita had fallen pregnant. He argued that he was a junior church pastor who could not afford a second child because he was earning very little income. In his fury George started to establish extra-marital relationships with 'small houses' and Mayita retaliated by also becoming a 'small-house' of a married man. Their marriage ended in divorce a few months after Mayita had given birth to their second daughter, and after she had endured a month long mental relapse which saw her spending a month in a psychiatric hospital.

Mayita's husband left Zimbabwe for Cape Town, South Africa with his 'small house' (mistress), to start a new life whilst Mayita stayed with the children in Harare. After about 7 years of single parenting, Mayita learnt that George was on a visit in Zimbabwe and she sent the children to him without notice. She felt that George was not being fair on her by leaving her to fend for their children on her own, when he knew that she is disabled and that she was surviving on a meagre salary. After her children had left, Mayita continued to search for a cure for her psychosocial impairment. However, Mayita experienced several episodes of sexual abuse during treatment sessions with religious prophets and traditional healers.

At about the age of 46, Mayita met Munya, her 47 year old boyfriend who is Schizophrenic. She expresses satisfaction with the persona of her boyfriend whom she describes as a man of sombre character. Before Mayita engaged in a love relationship with Munya, she would spend days looking at her ex-husband's photograph and wondering why he left her, but she argues that her new intimate relationship has improved her well-being and reduced the incidences of depression which she experienced before. However, she highlights that the opposite nature of their levels of libido, which she attributes to the effects of the medical drugs which they take for psychosocial impairment, creates challenges for them in their sexual relations. She registers disappointment with the fact that health care staff treat Mayita and her boyfriend as asexual beings on the grounds that they have impairments; hence the staff are not willing to discuss issues of sexuality with Mayita and her boyfriend. Mayita registers her desire to earn respectability by marrying her boyfriend.

Rudo's story of losses and hope

Rudo is a 50 year old woman who was raised by both her parents in her rural village home in *Murehwa*. She became Deaf at the age of 2 and she also became partially blind at the age of 42. Rudo's parents sought the divinations of traditional healers and religious prophets to establish the reasons why Rudo had become Deaf. After 4 years of relentlessly and unsuccessfully searching for a cure, Rudo was enrolled to start Grade 1 at a boarding school for the Deaf in Gweru, (about 350km away from their home village), because there was no school for the Deaf nearby. Whilst in boarding school, Rudo started to learn sign language by imitating what others were doing. Apart from acquiring scholastic education in Deaf school, Rudo also gained informal sexuality education about the elongation of labia from a friend.

Rudo did well in primary school, until she successfully completed her 7 years of primary education (grade 1 to grade 7) at the age of 13. Although she wanted to go to high school, she was told by her parents and teachers that it was not necessary because she is Deaf. Her parents ushered her into a special vocational training centre in the rural area of *Murehwa*, where she started to study towards a 2 year dressmaking course. She used to visit *vana tete hanzvadzi dzababa* (aunts, my father's sisters) during holidays, and it was during one of her such visits that she met a non-disabled man who was a friend of her aunt; the man raped her and broke her virginity when she was 16 years old. The rape case went unreported because Rudo decided to keep the incident to herself for fear of being blamed by her family.

Rudo started adolescence dating at the age of 17 when she got involved in an intimate partner relationship with Shingi, a young man who was also Deaf. The relationship lasted for 4 years, until Rudo had reached the age of 21 and her boyfriend asked her to marry him. Rudo's parents denied her permission to marry on the grounds that her brothers and sisters had not yet left home, hence she was not lonely. Rudo waited as she watched her siblings marrying partners of their choice one after the other. For about 14 years, Rudo was grounded at the family village homestead, until she reached the age of 35. She then decided to join a government project for the Deaf which had been set up near her rural home in *Murehwa*. She established an intimate partner relationship with Mafiyo, a Deaf man of her age. Rudo started to cohabit with Mafiyo and it was during this period of time that she fell pregnant with their first child. However, Mafiyo began to beat her up if she upset him in any way. She

was 36 years old when in 1997 she went to deliver her baby at a rural hospital in Murehwa. Rudo encountered serious communication problems because none of the health care staffers could speak sign language. Rudo blames such communication barriers for the resultant death of her baby girl during the child delivery process. After suffering the loss of her first baby, Mafiyo stopped beating Rudo up and for a season he treated her well. In the following year (1998), she fell pregnant again but when she was half way through her second pregnancy, the beatings from Mafiyo resumed. When her pregnancy reached full term she went to one of the major hospitals in the city, expecting to get better service. However, she discovered that none of the health care staff could speak sign language. She lost her baby boy during the child delivery process. Following the loss of her 2 babies during separate child delivery processes Mafiyo was confronted by Rudo's sister about his non-payment of *roora* (bride price) for Rudo. He was reminded of the traditional repercussions of not fulfilling such an important traditional practice; Rudo's parents could refuse to bury her body if Mafiyo had not paid *roora* and also Rudo could turn out to be *ngozi* (an avenging spirit) if she dies. Mafiyo relented and paid *roora* for Rudo. However after such a payment Mafiyo and his family began to demand a baby from Rudo, labelling her a Deaf old woman who was failing to give birth to live children. Rudo struggled to conceive for the 3rd time, and Mafiyo decided to impregnate a non-disabled 'small house' and divorced Rudo in the 5th year of their marriage. At the time of their divorce, Rudo was about 42 years old and it is at that time that she began to lose her sight and to also suffer from various illnesses. Rudo is not formally employed but she is a street vendor who sells mobile phone airtime, sweets and biscuits in **Kaguvi** Street in the city centre. After being disappointed by her Deaf husband, Rudo decided to have a relationship with a non-disabled man, believing that such a relationship would be more fulfilling. She discovered that the man only wanted sex from her and he was not willing to commit to marriage or to identify with her in public, hence she terminated the relationship. Rudo has now turned to Christianity, and she has learnt that having sex before marriage does not please God, so she is abstaining from sex until after marriage. Rudo is hoping to find a good man who will marry her. She argues that although she is 50 years old, she would still want to try and have a child because she has not yet reached the age of menopause.

Mako's story of exclusion and perseverance

At the time of the interview in 2014, Mako was 31 years old. Her parents divorced soon after her birth and when she was two years old, her mother immigrated to the city in search of employment. She left Mako in the care of her grandmother and *vana mainini* (her mother's younger sisters) in the village. Mako's father has kept her hidden from his family because his new British wife does not know that he had Mako before their marriage. Mako was raped by a non-disabled male relative when she was 7 years old. Mako found it difficult to disclose the rape because she was raised by guardians who would beat her up at the slightest excuse. At the age of 13, Mako was taught by her grandmother and other elderly women in the village to pull her labia. The elderly women underscored the principle of no sex before marriage.

Mako left the village at the age of 16 after she was diagnosed *nepfari* (with epilepsy). Mako's maternal family consulted traditional healers to seek divinations that would explain why epilepsy had come upon her. Another traditional healer revealed that the disgruntlement of the benevolent spirit of Mako's paternal grandmother was the cause of her impairment. *Mudzimu wambuya vake wakatsamwa* (the benevolent spirit of her grandmother is angry) because *Baba vake havana kurova guva rambuya vangu zvakanaka* (her father did not beat her grandmother's grave properly). Mako's family took a manifold approach in seeking treatment for her acquired impairment, which saw her weaving in and out of contemporary, traditional and religious modes of health care.

She was moved by her mother from the village to the city at the age of 17, after which she met her first boyfriend Tapiwa, who was about 10 years older than her. One day she subconsciously visited her boyfriend when she was in epileptic absentia and the boyfriend raped her. After 4 months she discovered that she had fallen pregnant and she eloped to Tapiwa's residence with the hope that he would marry her. Tapiwa refused to pay *roora* (the bride price) for Mako and he instead married a non-disabled woman with whom he had fathered a child in the previous year. He invited the woman to live with him in the same house where he was staying with Mako. After enduring ill-treatment from Tapiwa and his wife for about a year, Mako went back to her mother's house, taking her son with her. One year after leaving the father of her first son, Mako started dating Anesu in 2002. After a year of dating, Anesu paid *roora* (bride price) for Mako and they started to live together as

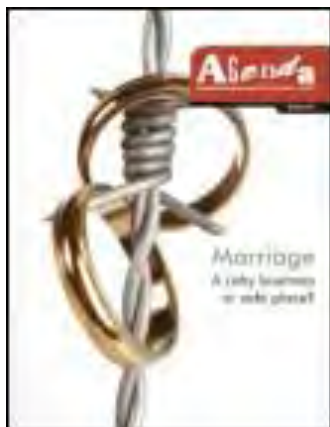
husband and wife in 2003. The marriage lasted for about 3 years before it ended in divorce after birthing one son. Mako's husband left her at her parents' home whilst she was in a 3 day static seizure at the end of which she realised that she had been abandoned by her husband. In the same year, Mako started dating a non-disabled boyfriend who lives in the same community as hers. She enhances eroticism in her sexual relations by using vaginal products. Mako noted that some married disabled and non-disabled men pursue disabled women for sex and not for love. Mako believes that epilepsy drugs have a negative effect on her experiences of sexuality because they cause pelvic bleeding and a low libido. Mako has learnt that Zimbabwean society is generally afraid of impairments. Mako hopes that her father will be able to openly identify with her as his daughter and that she will also be able to introduce her two sons to him. She also desires to marry her boyfriend and to establish a happy family.

Nyasha's story of searching for a cure for impairment

Nyasha is a 47 year old woman who was born and raised in her rural village in a big and poor family of 10 children. She became visually impaired at the age of 2 because she was not immunised against measles. She remembers being told that when she lost her sight her parents started blaming each other for having broken traditional taboos; her mother believed that Nyasha had lost her sight because her father had been promiscuous and vice versa. Nyasha's parents consulted several traditional healers and religious prophets in search for a cure for visual impairment; the efforts proved fruitless. Nyasha attended a school for the visually impaired and learnt Braille but she reports that she did not receive any sex education hence she struggled to manage her menstrual periods. Nyasha boasts pulled labia but she bemoans the fact that she has not been able to secure a marriage. She is formally employed as a Receptionist and she desires to marry.

Appendix 19: Publication in scientific journal (AGENDA Journal)

To cite this article: Christine Peta, Judith McKenzie & Harsha Kathard (2015): Voices from the periphery: A narrative study of the experiences of sexuality of disabled women in Zimbabwe, Agenda: Empowering women for gender equity
<http://dx.doi.org/10.1080/10130950.2015.1050783>



Voices from the periphery: A narrative study of the experiences of sexuality of disabled women in Zimbabwe

Christine Peta, Judith McKenzie and Harsha Kathard

abstract

This article forms part of a larger biographical narrative study in which the experiences of sexuality of 16 Shona women with disability in Zimbabwe were explored. The purpose of this article is to use a single case, that of Tsitsi,¹ to illuminate the intersectional nature of her experiences of sexuality. Her narrative is robust in illuminating the confluence of four themes found to be common across all the narratives of the larger study: 1) disregard and rejection; 2) health consequences of gendered sexual stigma; 3) gendered differences in experiences of disability; and 4) gendered cultural discourses on disability. These themes indicate that Tsitsi is located at the centre of a complex intersecting web of gender, disability, culture and sexuality. Her experiences of sexuality occur in a context in which her disability interacts with normative gender roles and power relations within heteronormative practices and popular cultural constructions of disability; these contribute to her vulnerability to coercive sexual practices, resulting in her infection with HIV. Despite these challenges her determination and resilience emerge through her strong entrepreneurial effort, strategy and hope.

keywords

disability, sexuality, gender, culture, Zimbabwe

Introduction

There is a paucity of research on the experiences of sexuality of disabled women. Most research on the relationship between disability and sexuality has been undertaken in Western countries (Cook, 2000; Plummer and Findley, 2012).

However, due to the diversity across political, economic and social systems that exists between contexts, even within Africa, such research may not be wholly applicable to disabled women in Zimbabwe where this study is based. It is therefore important to understand the experiences of sexuality of disabled women in Zimbabwe within their own contexts.

One of the reasons why women with disability have been marginalised in sexuality literature is that there is a general belief that disabled people are either asexual beings or sexual beasts who cannot control their sexual urges (Anderson and Kitchin, 2000). South Africa is currently leading the African continent in disability and sexuality research (Bleazard, 2010; McKenzie, 2012), and such research reveals that the intersection of disability and sexuality remains problematic for many.

This study explores the experiences of sexuality of women with disability in Zimbabwe to gain insights about their contextualised experiences.

Background

Zimbabwe enacted its first disability legislation in 1992 (Government of Zimbabwe, 1992), subsequent to which disability-related action in the country has placed a particular focus on education and employment. In this study we follow the broader United Nations Convention on the Rights of Persons with Disabilities (2008, article 1) guidelines, which state that:

“...persons with disabilities include those who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

Synonymous with the perspective of the World Health Organization (2011), we consider disability as a multifaceted interaction of the human body and the society in which the person lives. It therefore extends beyond the issues of education and employment toward full participation in all aspects of community life, including sexuality.

Sexuality is a central aspect of humanity and it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction (Glasier *et al*, 2006). Although views on sexuality and disability often vary among cultures, as previously noted, in many contexts discourses that construct disabled people as either asexual or hypersexual and/or as vulnerable to sexual abuse abound (Anderson and Kitchin 2000). Further, the gendering of sexuality points to the fact that men and women with disabilities share different experiences of sexuality (Choruma, 2007). There is therefore a need to listen to distinctive feminine and masculine voices.

Sexuality and gender are interrelated social constructs that give form and shape to one another (Tamale, 2011). By using a critical gender lens this study acknowledges that persons with disability are not gender-neutral beings, but their interests and needs are shaped by gender identity (Abu-Habib, 1997). However, isolating gender and treating it as a stand-alone social life identity is tantamount to privileging gender at the expense of other identity markers (Yuval-Davis, 2006). We therefore consider

gender within an intersectionality model that asserts the interdependence of differentiating identity markers within a society. Such identity markers are dynamically interwoven into an interlocking cycle of people's interaction with their environments.

Methodology

This article forms part of a larger biographical narrative study in which the experiences of sexuality of 16 Shona women (ages 18-65 years) with disability in Harare, Zimbabwe, were explored using a narrative methodology within a qualitative research design. The study included participants with diverse forms of disability (physical, mental or sensory). Purposive and snowball sampling techniques were used to select participants.

The field researcher is of similar race, culture and gender affiliation as the participants, and this assisted in building rapport. All women invited to participate in this study readily accepted, describing the invitation as 'a chance of a lifetime'. They considered the research to be valuable in providing the opportunity for them to speak about important silenced issues in their lives.

Interviews took place in the privacy of participants' homes, in a private room of a city office block (transport was provided for those with mobility problems) or in private rooms at rehabilitation institutions. A biographic narrative interpretive method (BNIM) was used to gather the data, which included three interview sessions outlined below.

In the first interview the researcher began with a single question-inducing narrative as follows:

"As we have discussed before, I am researching on the experiences of sexuality of disabled women in Zimbabwe. Could you please tell me the story of your life, including your experiences as a disabled woman living in Zimbabwe, your intimate love relationships and sexuality involvements, including pregnancy and child birth experiences that have been important for you up to now? Begin wherever you like, I will not interrupt. I will just take some notes in case I have any further questions after you have finished telling me about it all."

The researcher then listened to the participants' entire narrative and took a few notes without asking any questions. Such an approach arguably reduces researcher/participant power relations and does not interrupt the narrative flow of the participant, who ends the sub-session in her own time and in her own way (Wengraf, 2001). Tsitsi ended sub-session 1 by saying "I think I have given you my whole life. That is all that happened, that is my story."

More in-depth data about particular incident narratives was sought in the second interview session, held as a follow-up to the first on the same day but with a break of about 15 minutes. The participant and not the researcher set the agenda for this interview. The principle of the second interview session was to only ask questions about issues that were raised in the first interview, in the order in which they were raised and using the exact words that were used by the narrator, in order to maintain

the gestalt of the participant (Wengraf, 2001). For example: “You said Farai raped you, he broke your virginity and you got pregnant. Do you remember any particular incident about that time when all that was happening?”

The third interview sessions enabled the researcher to meet with each participant again on a different day (after 1-8 weeks) to ask direct questions that are associated with the research agenda, to clarify ambiguous points and to gather more biographical data. A major challenge was that some participants with psychiatric disability went into mental relapse between the second and third interviews, and the researcher had to wait until such participants recovered in order to continue with the interviews. However, the BNIM method proved to be extremely effective in drawing explicit and rich qualitative data on the experiences of sexuality of the participants. Compared to semi-structured interviews, that are strongly guided, BNIM permits the participant to give her own form and sequence of what she chooses to remember and to tell as the researcher gathers details of significant occurrences and experiences from the interview (Wengraf, 2001). The BNIM interviews lasted between 2 to 7 hours in all per participant. Interviews were systematically recorded (audio-recorded and field notes) and transcribed verbatim.

Data analysis

Although the entire data set of this study was subjected to both narrative analysis and analysis of narratives, in this article we present analysis of the narrative for one story, named as Tsitsi's story. This particular personal story reflects many common themes across all of the narratives. Thus we use this opportunity to explore issues that are common across participants by utilising this one powerful narrative.

Compared to narrative analysis, which produces whole life stories, analysis of narratives produces distinctive themes (Polkinghorne, 1995). Although the analysis of narratives employs paradigmatic analysis, which generates themes as is common in other qualitative research studies, what differentiates it from other approaches is that it uses stories as its primary data for analysis.

Ethical issues

Ethical approval for this study was granted by the University of Cape Town (581/2013) and the Medical Research Council of Zimbabwe (MRCZ/B/1789). Informed consent was obtained in the language that each participant was most comfortable with, Shona (vernacular) or English. The field researcher was fluent in both these languages. Participants were assured of confidentiality, and informed of the benefits and risks of participating in the study and that they had the right to refuse to participate or to withdraw at any point without giving an explanation if they so wished. The letter of information and consent form was translated into Shona and also braille to cater for blind participants. A sign language interpreter was used for deaf participants. Information was read out to participants who were unable to read, in the language of their choice, in the presence of a witness. Pseudonyms are used to protect the identity of participants.

Tsitsi's story: A synopsis

At the time of the interview in 2014 Tsitsi was 38 years old. Her infection with polio at the age of two left her with atrophied legs of different lengths, causing her mobility problems in a rural area where people often move from place to place on foot. She

was raised by her **mainini** (mother's younger sister) in her mother's rural village, because her father was absent and her mother was working in the city as a nanny, and was not allowed to live with children in the servants' quarters allocated to her by her White European descent employers.

She started menstruating at the age of 13, reusing a few pieces of cloth during such times. Tsitsi reported that she was raped and impregnated twice by an able-bodied man who lived in a neighbouring village, resulting in the birth of her two sons. With the assistance of her mother and grandmother she raised the children on her own. At the age of 33 Tsitsi moved to the city to search for economic opportunities. However, in her search for love and belonging she reported that she experienced many incidents of sexual abuse, and she acquired HIV at the age of 35. In spite of reporting that she confronted difficulties in her experiences of sexuality, it was evident that Tsitsi developed a strong entrepreneurial spirit, resilience and hope.

Disregard and rejection

Tsitsi's story reveals that her experiences of sexuality are bound up with rejection by male partners on the basis of not being an acceptable long-term partner. Her experience of intimacy with men was further characterised by coercive and at times violent sexual practices that were also linked to negative consequences including unwanted pregnancies, rejection and HIV infection. Her disability was experienced as intersecting with normative gender roles and gender power relations in complex ways to facilitate a particular vulnerability to unsafe and coercive sexual practices. For example, Tsitsi was reportedly raped and fell pregnant when she was 19 by Farai, an able-bodied man who lived in their neighbourhood, and who had earlier claimed to love her:

"Farai told me that I am beautiful and he loved me, but I was not sure whether to love him or not, and then I started to love him, because I was thinking that he loves me for sure. Then one day I met him, and he said 'Let me show you a shorter route to your homestead'... he pulled me into the bush and fondled my breasts. Farai raped me, he broke my virginity and I got pregnant."

Research has indicated that gender-based violence (GBV) is a worldwide problem which many women are vulnerable to, including those in the developed world (Russo and Pirlott, 2006). Sexual coercion represents a form of gendered power relations which is common in heterosexual relationships (Kalichman *et al* 1998, Wood and Jewkes, 1997). Whilst the visibility of literature on GBV against girls and women worldwide is unquestionable; very little research has been undertaken on GBV that involves disabled women in particular. In Tsitsi's experience then, her disability, coupled with gender power relations and her need to be in a loving relationship, facilitated a vulnerability to GBV.

Social and gendered stigma related to disability further undermined her power to determine her future consequences. Narrating an incident that transpired after the rape, Tsitsi recounts: "I told Farai that I was pregnant and he refused to marry me. He said 'I can't marry you because **uri chirema chemukadzi**' [you are a disabled woman]." Translated into English, **chirema** means a heavy object to carry. Such a construction of disability intersects with gender relations to undermine the wellbeing

of a disabled woman. It is evident that normative assumptions underlying disability discourse make us perceive some bodies as lacking and others as superior. It is apparent that Tsitsi expected marriage to be offered after the rape and pregnancy. Such an expectation may be attributed to normative gender roles and power relations where dominant representations of love are linked to penetrative heterosexual and coercive practices are not endemic (Wood and Jewkes, 1997).

Tsitsi reported that Farai resurfaced in her life when she was 21 years old, when their first son was 14 months old: "He raped me again and I became pregnant, but he went to marry another girl who was not disabled. I gave birth to a disabled son and my mother and my grandmother helped me to look after my children." Tsitsi narrated that at the age of 33 she left her children with her grandmother in the village and went to the city to seek economic opportunities. She did not anticipate that city life would further facilitate a vulnerability to sexual abuse.

She reportedly approached Farai's brother for assistance:

"I went to his brother and I said 'Please can you find me a job so that I can work and look after my children'. The brother said 'It's OK! I can help you to get a job, but you have to have sex with me first.' I was very desperate but it was hard for me to have sex with his brother. So I said 'I cannot do it because you are the brother to the father of my children' and I went away."

As narrated above, Tsitsi was offered the possibility of getting a job in return for sex. There is a growing body of work on transactional sex in South Africa (Hunter, 2002; Selikow, 2002). Yet Hunter (2002), who examines the materiality of everyday sex, also argues that it should not be assumed that women are passive victims since at the negotiating table of such relations women may either challenge or reinforce patriarchy. Despite her disadvantaged socio-economic status, Tsitsi resisted the transactional sexual advances of Farai's brother, and in the process practices resistance to normative gendered transactional practices.

In a show of a strong entrepreneurial drive Tsitsi decided to set herself up as an informal vegetable vendor, using a donation from a local Roman Catholic Church. She recounts:

"I saw that I was raped and now I have two children and I have to work for my children, but I saw that now I can't get a job, so I said let me use this ten dollars to start to sell vegetables. I found a place to stay and later I moved my children from the village to stay with me. Well-wishers sent my son to hospital and his legs were straightened and he was given a wheelchair. I was happy."



Figure 1. Tsitsi's vegetable stall.



Figure 2. Tsitsi serving a customer at her vegetable stall.

However, coming from a rural background where she was positioned by both family and community as unlovable and unfit to live in ‘normal society’ because of her disability, Tsitsi continued to search for love and belonging: “In the village no one liked me, everyone hated me because of my disability, and everyone was just saying I am a useless person.” The time that she spent living in the city helped Tsitsi to validate herself as a woman who is deserving of a stable, reciprocal, intimate partner relationship: “In the city I saw that other disabled people were having also their love relationships and I also desired to have one”.

Health consequences of gendered sexual stigma

The negative construction of disabled women and rejection as potential long-term partners further played out in Tsitsi’s life narrative by exposing her to reproductive health risks. While a valuable livelihood, Tsitsi’s informal business and its location by the roadside reportedly exposed her to several sexual predators who came to buy vegetables or who passed by en route to their destinations. In her continued search for and repeated breakdown of intimate partner relationships Tsitsi was infected with HIV, as discussed below.

It appears that her openness in searching for love and belonging and her attempts to cope with loneliness entangled her in a cycle where she hoped to find ‘true love’ from the intimate partners that she engaged in sexual relations with:

“What happens is a man will come and say ‘I love you’, then I say it’s OK! Then we have sex and then he dumps me. Even if I meet him the following day he will just look sideways as if he doesn’t know me, and he behaves as if he has never seen me before. So this forces me to find another one, because I will be feeling lonely. So I end up sleeping with too many men, not because I am a prostitute but because they just come and go”.

It appears that Tsitsi became more vulnerable to acquiring HIV infection through engaging in multiple partner relationships as she struggled to acquire a stable, reciprocal intimate partner relationship. Tsitsi tells of when at the age of 35 she was involved in an intimate partner relationship with an able-bodied man that she claims infected her with HIV:

“I can’t forget Mudiwa because he came and he gave me AIDS. He started to have sex with me and then he said we should have a baby. So I said to him, I heard that if people want to have a child they should go for AIDS test. So he said it’s not important. He said to me: ‘So you think you don’t have AIDS? You should know that you have AIDS because I have given you AIDS already’.”

Tsitsi reportedly thought that Mudiwa was joking, until a few weeks later when she heard that he had fallen ill and died at a hospital in his rural village in Mount Darwin, northeast Zimbabwe. After receiving the news from Mudiwa’s brother Tsitsi narrated that she panicked as she remembered the deceased’s words concerning HIV/AIDS:

“So for the first time I said ‘Let me go and have an AIDS test’ ... they tested me and they said ... you are HIV positive ... I started to cry, I cried and cried and cried. I was now thinking about Mudiwa who had died, and I thought that he knew that he had AIDS, that’s why he was talking like that.”

When Tsitsi told her mother that she was now HIV positive, her mother shouted at her. She recalls her mother saying: “**Ropa rako rakabatwa EDZI ko makondomu kwanga kusina here?**” [Your blood was found with AIDS, were there no condoms?]. This response of Tsitsi’s mother is synonymous with the ‘you should have known better’ concept which is illuminated in a South African study of health-related stigma which drew lessons from HIV/AIDS-related literature (Deacon, 2006). Such stigmatising and blaming discourses may result in withdrawal, which disadvantages the infected who may then refrain from reaching out for the necessary assistance.

At the time of the interview Tsitsi said she was having a sexual relationship with Nhamo, her unemployed able-bodied boyfriend aged 54 (about 16 years older than her). When Tsitsi met Nhamo she advised him of her HIV-positive status, and that she had been living with HIV for about two years: “I told him that I have AIDS, then he looked at me and said ‘No! I don’t think you have AIDS because you look very well’.” To convince Nhamo that she is indeed HIV positive, Tsitsi reportedly showed him her current medical records and the antiretroviral drugs that she is taking: “So I showed him my cards from the hospital and the ARV tablets that I take, and he said it doesn’t matter, he still loves me.”

Nhamo reportedly refuses to use condoms during sex: ***“Akati handingadye siwiti nepepa rayo nekuti hangingazonzwi kunaka kwayo kwese nekuda kwepepa.”*** [He said I can’t eat a wrapped sweet because I won’t be able to enjoy its full sweetness because of the wrapping]. Tsitsi appreciates the fact that she is not stigmatised by Nhamo on the grounds that she is disabled and HIV positive: “I think he is a nice man, he is not worried about my AIDS or condoms or my disability or anything like that.” Although women may be aware of the health consequences of not using condoms, they perceive the refusal of their partners to use condoms as acceptable within their relationships (Naidu and Ngqila, 2013). In addition, women may regard such men as ‘good’, as long as they are not being physically violent or aggressive towards them.

A study carried out in South African urban townships revealed that some men who do not use condoms during sex believe in the concept of ***‘tata ma chance’*** [take a chance], which is derived from the slogan of the South African Lottery (Selikow *et al*, 2002). Such a notion attributes death to fate, and argues that people cannot defend themselves from death because death happens at pre-set times.

Tsitsi reportedly appreciates the fact that Nhamo has stayed with her for a full year, since most of the intimate partners she had previously would just have sex with her and leave her within periods ranging from one day to a few weeks: “... I have had this man now for one year and I think he is better, because others would come and have sex with me and go ... sometimes for one day and sometimes for a few days”. It is evident that in this case material resources intersect with gender and disability to earn a long-term relationship for a disabled woman, albeit constrained by masculinities in negotiating safe sex: “Nhamo is 54 but he is not working, we use the money that I get from selling vegetables.” Common gendered patterns of poverty have indicated that women often give in to demands for unprotected sex in order to gain economic advantage from men (Hershey, 2000). However, considering that Tsitsi is reportedly the breadwinner in the relationship, it is evident that her reason for giving in to unprotected sex is to maintain a long-term intimate partner relationship.

Gendered differences in experiences of disability

Disability interacts with gender in multiple ways, as illustrated above. When it comes to disabled men, Tsitsi’s narrative indicates that although some disabled men may share common characteristics of disability with a disabled woman, some are insensitive towards women who have a disability:

“He was in a wheelchair but he said to me ‘What do I want a disabled woman for? I don’t like disabled women because they are useless in bed, so I go for able-bodied women because they are good in bed’.”

It is evident that in a patriarchal context disability undermines femininity and sexuality, and a woman may end up being judged as ‘damaged goods’ (Boylan, 1991). Tsitsi gave another example of an intimate partner relationship that she had with a physically disabled boyfriend Tamuka, believing that since they were both disabled they could build a good relationship:

“I learnt that it doesn’t matter if a man is disabled or not, they are all the same. A disabled man can be worse than an able-bodied. This disabled man said ‘I am more superior to you because I have a penis and you don’t have one, even if I am on wheelchair, but I have a penis’. Disabled men can also be promiscuous, much more than able-bodied men.”

Whilst manhood is believed to be disrupted by disability, as both disabled men and disabled women become less gendered in equivalent stereotypes that relegate both of them to femininity (Nario-Redmond, 2010), Tsitsi’s narrative does not bear this out. As shown above, Tsitsi’s experiences of sexuality indicate that disability does not deter a man with disability from claiming space in hegemonic masculinities relative to a woman with disability.

In further comparing disabled men to able-bodied men, Tsitsi said:

“An able-bodied man just wants to take off my clothes to check if I have a vagina. I think in his mind he will be thinking ‘This woman is disabled, so does she have a vagina, can she have sex? Let me take off her clothes and see. Let me also have sex with her to see if she can do it’.”

Disability literature reveals that prospective partners may have negative perspectives on the sexual potential of disabled women and their ability to offer reciprocal pleasure, love and friendship (Hershey, 2000). In this instance questions relating to Tsitsi’s capacity to be sexual are raised, thereby conflating the notion of disability and asexuality, as previously noted. It is evident that in a patriarchal context, where femininity is associated with a receptive, docile sexuality (Naidu and Ngqila, 2013; Zinanga, 1996), Tsitsi’s sexuality still comes under question because she is disabled. However, as illuminated below, cultural issues maintain omnipresence in Tsitsi’s relentless search for love and belonging.

Gendered cultural discourses on disability

Tsitsi’s narrative indicates that particular contexts of local popular belief may further undermine a disabled woman’s experiences of relationships and sexuality: “Farai said he doesn’t want me because I have evil spirits that caused my disability. Even other people in the village were saying the same.” The Zimbabwean cultural conceptualisation of disability, which associates disability with evil spirits (Harley and Mpofo, 2002) may further constrain disabled women’s access to a reciprocal intimate partner relationship. Zimbabweans do not generally follow the practice of arranged marriage, but the prevalence of interference from families in heterosexual relationships exacerbates the problem for disabled women (Pasipanodya, 2013). Pasipanodya (2013), for example, notes that Zimbabwean men may face immense cultural pressure if they wish to marry a disabled woman.

The cultural conceptualisation of disability which associates disability with evil spirits may also impact on disabled women’s experiences in contemporary healthcare centres if staff subscribe to such notions. For example, Tsitsi described how healthcare staff who delivered her second son drew on these discourses when her son was born to publicly ‘other’, and humiliate her:

“They said come and see this evil thing that is here, his legs were not straight, they were bent like this [going to the back touching his back]. I said God, now people think I have more evil spirits, but I was happy that now I was a mother of two sons, because some people were saying disabled women cannot have children.”

The attitudes of health care staff described by Tsitsi above are synonymous with observations made in a study of discrimination against disabled women in State reproductive health clinics in South Africa. The study concluded that the sexuality and reproduction processes of disabled women are sites of oppression which undermine their personal dignity and human rights (Mgwili and Watermeyer, 2006).

The notion that disabled women are unable to give birth to children or raise them because they themselves are in need of being taken care of has been widely documented (Traustadottir, 1990). Such disability discourses may further undermine disabled women in a context where the sexuality of a woman is often associated with reproduction and nurturing children.

Conclusion

Tsitsi's experiences of her sexuality, gender and relationships, point to a range of challenges that she confronts as a Shona woman living in Zimbabwe. The complex intersection of her disability with normative gender roles and power relations within heteronormative practices, as well as within popular constructions of disability and disabled women in particular, has been shown to negatively impact on Tsitsi's general health, wellbeing and satisfaction in relationships. This intersection also facilitated her vulnerability to inequitable, unsafe and coercive sexual practices that resulted in her becoming infected with HIV. However, there is also evidence of family and community support and personal agency, where Tsitsi exhibits determination and resilience.

This article has shown that Tsitsi is not a passive recipient of identity markers, but she engages in a dynamic process of practising each aspect of identity, as informed by other identities that she claims. As an entrepreneur Tsitsi earns material resources that appear to mitigate aspects of gendered disability, such as the notion that disabled women are not long-term relationship prospects for men; thus as a resourced person she is able to engage in a long-term relationship with an able-bodied boyfriend who is economically reliant on her. Yet she is still unable to negotiate safer sex, given continued practices of male dominance in heterosexual relationships. It is therefore evident that various forms of intersectionality may not only facilitate oppression, but they may also open 'opportunities' for a disabled woman in heteronormative experiences of sexuality.

This article has also highlighted the need for a more nuanced account of masculinity. Whilst there is evidence that the workings of heterosexual norms often award more power, voice and 'privileges' of sexuality to men, it is also evident that some 'privileges', such as non-condom use, are mutually shaped by gender relations in sexuality. Tsitsi considers her engagement in risky sexual behaviours with Nhamo as acceptable in her relationship, because she regards him as a 'good' man who does not stigmatise her for her disability and HIV-positive status.

In conclusion, we have applied a feminist intersectional approach to illuminate a perspective of the gendered, intersectional experiences of sexuality for disabled women, through engaging with one story from a disabled woman in a particular cultural context. The case study has foregrounded the intersection of particular discourses of disability, gender, culture, class and sexuality that shape the narrator's experiences of sexuality, relationships, family, livelihood and life in general.

Whilst it is not possible to generalise the findings documented here, we believe that by openly sharing her experiences of sexuality Tsitsi may offer a voice that resonates with others in more or less similar situations. Given the scholarly and public silencing of certain voices on disability, we call for further research that facilitates the voices of both disabled men and disabled women in multiple contexts, in particular those that have been marginal in global terms such as in many African and global Southern contexts.

Acknowledgements

This study was supported by Canon Collins Educational and Legal Assistance Trust, Margaret McNamara Memorial Fund (World Bank) and the Council for the Development of Social Science Research in Africa.

Note

1. Pseudonym chosen by the participant herself.

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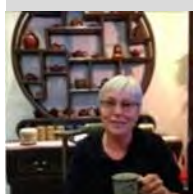
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